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Human Services

https://mn.gov/dhs/

AT A GLANCE

- Health Care: In 2021, each month an average of 1,188,285 people received healthcare coverage through Medical Assistance and 92,912 through MinnesotaCare
- Food: Over 445,000 people received assistance through the Supplemental Nutrition Assistance Program (SNAP) each month in 2021
- Economic Support: About 26,000 families received assistance through the Minnesota Family Investment Program (MFIP) and Diversionary Work Program (DWP) each month in 2021
- Child Support: More than 314,000 custodial and noncustodial parents and their 220,000 children received child support services in 2021
- Child Care: An average of 29,000 families received child care assistance per month in 2021
- Housing: About 21,319 people received Housing Support services each month in 2021
- Substance Use Disorder Treatment: There were 58,563 admissions for substance use disorder treatment in 2021.
- DHS Direct Care and Treatment: Provided services to more than 12,000 people in 2021
- In FY21 DHS all funds spending was $20.3 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.

Our work is guided by the following values:

- 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.

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.

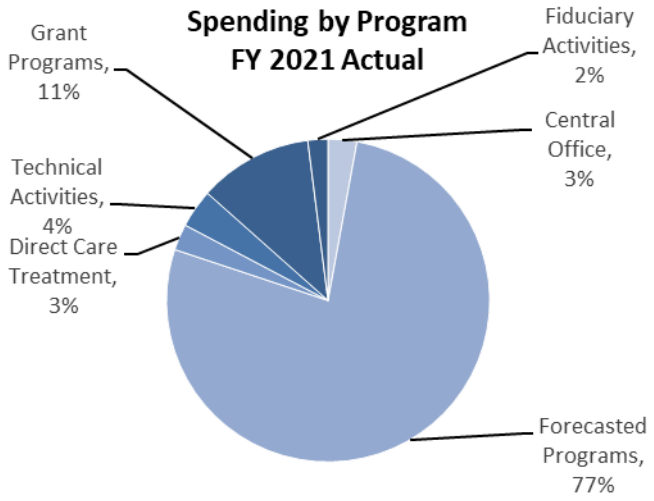
Examples of our work include:

- 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.

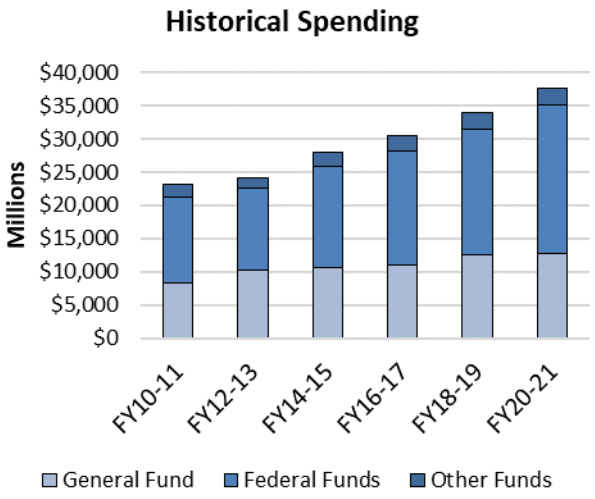
- Grant programs to support local delivery of human services for populations in need, including recent refugee immigrant populations, adults and children needing behavioral health services, people who are deaf or hard of hearing, people with disabilities, and older adults.
- Direct care provided through 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.

BUDGET

Below you will find all funds spending by program in fiscal year 2021. The majority of spending occurs within forecasted programs. Forecasted programs include: Medical assistance (89%), MinnesotaCare (3%), Economic support programs (6%) and other healthcare programs (2%).



Source: Budget Planning & Analysis System (BPAS)



Source: Consolidated Fund Statement

STRATEGIES

The 2020-2022 DHS Strategic Plan (https://mn.gov/dhs/general-public/about-dhs/strategic-plan/) includes three key initiatives, nine goals, and 31 specific strategies striving to improve programs and services for the people DHS serves and to create a brighter future for Minnesota. The next strategic plan is under development and will build upon these initiatives.

Key Initiative: Our Stand
Better health, fuller life and lower cost for Minnesotans working to achieve their highest potential.
Goals:

1. Extend the reach and impact of our programs across all communities.
2. Reduce disparities and make access to services easy.
3. Increase partnership, engagement and public confidence in our services.

Key Initiative: Culture of Equity

Commitment to a culture of equity that advances equitable outcomes for communities across Minnesota.

Goals:

1. Institutionalize equity practices across the agency.
2. Provide employees with the tools and skills to establish equity in the workplace.

Key Initiative: Operational Excellence

National ranking as a well-run state agency.

Goals:

1. Rebuild trust with our partners, with the people we serve and with all Minnesotans.
2. Improve workplace culture and employee experience.
3. Improve the delivery of technology across the human services system.
4. Reduce DHS's carbon footprint.

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)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	6,439,370	6,230,161	6,534,793	7,728,140	8,205,645	8,816,042	9,100,463	9,063,260
1200 - State Government Special Rev	4,311	4,316	4,210	4,415	4,299	4,299	5,307	5,575
1201 - Health Related Boards				522	279	459	279	459
1251 - COVID-19 Minnesota	114	5,617						
2000 - Restrict Misc Special Revenue	300,396	123,563	144,443	152,823	150,732	150,828	149,851	149,983
2001 - Other Misc Special Revenue	365,636	498,968	530,271	645,003	540,266	528,949	540,330	528,981
2005 - Opiate Epidemic Response		7,663	7,568	34,855	8,135	18,446	14,781	19,062
2360 - Health Care Access	664,428	687,782	681,992	430,395	982,119	686,395	997,556	1,595,291
2403 - Gift	3	889	1	36	32	32	32	32
3000 - Federal	10,082,930	11,551,448	14,301,610	16,672,628	15,333,789	15,262,406	15,355,789	15,277,732
3001 - Federal TANF	228,844	219,737	182,224	266,213	275,549	275,941	276,953	281,694
3010 - Coronavirus Relief	24,057	263,686	24,323					
3015 - ARP-State Fiscal Recovery			114,913	29,997				
4100 - SOS TBI & Adol Ent Svcs	1,432	1,281	841	776	798	813	798	813
4101 - DHS Chemical Dependency Servs	16,378	16,202	16,252	18,911	19,315	19,592	0	0
4350 - MN State Operated Comm Svcs	111,996	114,308	121,856	138,247	141,998	144,574	141,998	144,574
4503 - Minnesota State Industries	1,164	738	1,376	1,407	1,407	1,407	1,407	1,407
4800 - Lottery	1,553	1,828	1,670	1,983	1,896	1,896	1,896	1,896
4925 - Paid Family Medical Leave							2,649	
6000 - Miscellaneous Agency	16,859	12,852	11,297	215,109	215,109	215,109	215,109	215,109
6003 - Child Support Enforcement	615,778	589,719	549,644	641,955	641,955	641,955	641,955	641,955
Total	**18,875,249**	**20,330,758**	**23,229,284**	**26,983,415**	**26,523,323**	**26,769,143**	**27,447,153**	**27,927,823**
Biennial Change				11,006,692		3,079,767		5,162,277
Biennial % Change				28		6		10
Governor's Change from Base								2,082,510
Governor's % Change from Base								4

Expenditures by Program								
Central Office Operations	586,590	579,546	600,904	799,189	659,549	617,957	909,453	808,623
Forecasted Programs	15,071,521	15,582,068	18,392,058	20,865,524	20,946,505	21,385,545	21,073,367	21,829,574
Grant Programs	1,369,514	2,314,524	2,409,875	3,003,514	2,623,205	2,468,609	3,157,620	2,945,007
Direct Care and Treatment	523,308	528,546	556,731	611,127	603,491	606,455	656,146	694,741

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Fiduciary Activities	629,799	597,082	555,448	851,627	851,627	851,627	851,627	851,627
Technical Activities	746,147	775,992	775,597	914,120	900,848	900,837	900,848	900,837
DHS Federal Admin Reimbursement	(51,630)	(46,998)	(61,329)	(61,686)	(61,902)	(61,887)	(101,908)	(102,586)
Total	**18,875,249**	**20,330,758**	**23,229,284**	**26,983,415**	**26,523,323**	**26,769,143**	**27,447,153**	**27,927,823**

Expenditures by Category

Compensation	684,219	694,003	719,950	799,785	799,629	772,003	937,168	942,401
Operating Expenses	963,447	968,634	991,518	1,381,171	1,249,448	1,251,195	1,408,365	1,338,788
Grants, Aids and Subsidies	16,643,054	18,118,509	21,010,354	24,204,477	23,876,435	24,148,119	24,543,815	25,089,507
Capital Outlay-Real Property	607	642	938					
Other Financial Transaction	635,552	595,969	567,853	659,668	659,713	659,713	659,713	659,713
Total Before DHS Federal Admin Reimbursement	**18,926,879**	**20,377,756**	**23,290,613**	**27,045,101**	**26,585,225**	**26,831,030**	**27,549,061**	**28,030,409**
DHS Federal Admin Reimbursement	(51,630)	(46,998)	(61,329)	(61,686)	(61,902)	(61,887)	(101,908)	(102,586)
Total	**18,875,249**	**20,330,758**	**23,229,284**	**26,983,415**	**26,523,323**	**26,769,143**	**27,447,153**	**27,927,823**

Total Agency Expenditures	18,875,249	20,330,758	23,229,284	26,983,415	26,523,323	26,769,143	27,447,153	27,927,823
Internal Billing Expenditures	68,310	36,739	66,490	90,461	86,626	86,628	86,626	86,628
Expenditures Less Internal Billing	**18,806,939**	**20,294,019**	**23,162,794**	**26,892,954**	**26,436,697**	**26,682,515**	**27,360,527**	**27,841,195**

Full-Time Equivalents	**7,122.24**	**6,895.23**	**6,787.11**	**7,120.10**	**7,024.95**	**6,907.66**	**8,363.42**	**8,365.22**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In	5,354	554,986	19,008	69,021				
Direct Appropriation	7,221,020	6,572,979	6,890,253	7,930,171	8,476,112	9,088,907	9,410,395	9,375,644
Receipts	794	1,197	1,819	1,959	2,101	2,206	2,101	2,206
Transfers In	121,355	170,389	114,751	75,798	51,616	20,304	51,616	20,304
Transfers Out	356,806	372,336	342,325	304,172	279,331	250,537	279,395	250,569
Cancellations	490,841	647,341	35,411					
Balance Forward Out	25,807	18,086	69,023					
Expenditures	**6,475,069**	**6,261,788**	**6,579,073**	**7,772,777**	**8,250,498**	**8,860,880**	**9,184,717**	**9,147,585**
DHS Federal Admin Reimbursement	(35,699)	(31,627)	(44,281)	(44,637)	(44,853)	(44,838)	(84,254)	(84,325)
Expenditures after Federal Admin Reimbursement	**6,439,370**	**6,230,161**	**6,534,793**	**7,728,140**	**8,205,645**	**8,816,042**	**9,100,463**	**9,063,260**
Biennial Change in Expenditures				1,593,402		2,758,754		3,900,790
Biennial % Change in Expenditures				13		19		27
Governor's Change from Base								1,142,036
Governor's % Change from Base								7
Full-Time Equivalents	4,297.23	4,157.91	4,096.61	4,367.04	4,339.95	4,263.42	5,666.08	5,702.47
1200 - State Government Special Rev								
Balance Forward In		11		116				
Direct Appropriation	4,299	4,299	4,299	4,299	4,299	4,299	5,307	5,575
Open Appropriation	22	15	27					
Cancellations		9						
Balance Forward Out	11		116					
Expenditures	**4,311**	**4,316**	**4,210**	**4,415**	**4,299**	**4,299**	**5,307**	**5,575**
Biennial Change in Expenditures				(2)		(27)		2,257
Biennial % Change in Expenditures				(0)		(0)		26
Governor's Change from Base								2,284
Governor's % Change from Base								27
Full-Time Equivalents	37.00	36.23	34.63	34.63	34.72	34.70	35.57	36.30
1201 - Health Related Boards								
Direct Appropriation				522	334	574	334	574
Transfers Out					55	115	55	115

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures				**522**	**279**	**459**	**279**	**459**
Biennial Change in Expenditures				522		216		216
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								0

1251 - COVID-19 Minnesota

Balance Forward In		1,905						
Direct Appropriation	2,018	13,300						
Cancellations		9,588						
Balance Forward Out	1,904							
Expenditures	**114**	**5,617**						
Biennial Change in Expenditures				(5,731)		0		0
Biennial % Change in Expenditures				(100)				
Governor's Change from Base								0
Governor's % Change from Base								

2000 - Restrict Misc Special Revenue

Balance Forward In	73,764	38,201	43,126	26,342	22,346	17,195	22,346	17,195
Receipts	156,750	118,949	124,628	148,111	144,895	148,079	144,014	147,234
Transfers In	140,916	10,053	14,020	9,526	11,463	10,211	11,463	10,211
Transfers Out	41,132	12,795	10,989	8,810	10,777	9,525	10,777	9,525
Balance Forward Out	29,903	30,845	26,343	22,346	17,195	15,132	17,195	15,132
Expenditures	**300,396**	**123,563**	**144,443**	**152,823**	**150,732**	**150,828**	**149,851**	**149,983**
Biennial Change in Expenditures				(126,693)		4,294		2,568
Biennial % Change in Expenditures				(30)		1		1
Governor's Change from Base								(1,726)
Governor's % Change from Base								(1)
Full-Time Equivalents	157.73	150.74	157.95	158.89	173.34	170.77	173.34	170.77

2001 - Other Misc Special Revenue

Balance Forward In	31,027	61,662	71,554	46,038	40,032	46,038	40,032	46,038
Receipts	225,321	268,379	280,191	414,820	322,699	314,714	322,699	314,714

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Transfers In	331,967	368,806	238,496	226,779	226,175	228,753	226,239	228,785
Transfers Out	202,410	166,131	13,935	2,602	2,602	2,602	2,602	2,602
Balance Forward Out	20,268	33,748	46,036	40,032	46,038	57,954	46,038	57,954
Expenditures	**365,636**	**498,968**	**530,271**	**645,003**	**540,266**	**528,949**	**540,330**	**528,981**
Biennial Change in Expenditures				310,670		(106,059)		(105,963)
Biennial % Change in Expenditures				36		(9)		(9)
Governor's Change from Base								96
Governor's % Change from Base								0
Full-Time Equivalents	529.91	530.50	529.80	529.80	438.58	413.86	438.58	413.86

2005 - Opiate Epidemic Response

Direct Appropriation		13,828	12,606	34,855	8,135	18,446	14,781	19,062
Open Appropriation			1					
Transfers Out		5,439						
Cancellations		726	5,039					
Expenditures		**7,663**	**7,568**	**34,855**	**8,135**	**18,446**	**14,781**	**19,062**
Biennial Change in Expenditures				34,760		(15,842)		(8,580)
Biennial % Change in Expenditures						(37)		(20)
Governor's Change from Base								7,262
Governor's % Change from Base								27
Full-Time Equivalents		0.94	1.00	1.00	3.34	2.76	5.34	4.76

2360 - Health Care Access

Balance Forward In	124	1,240	72	4,671				
Direct Appropriation	663,293	684,953	725,136	446,179	1,003,130	707,846	1,019,172	1,617,954
Open Appropriation	177	122	219	219	219	219	219	219
Receipts	30,816	33,049	6,152	5,885	5,329	4,889	5,329	4,889
Transfers In	3,863	4,141	73,711		37,990		37,990	
Transfers Out	15,061	14,889	83,848	9,510	47,500	9,510	47,500	9,510
Cancellations	2,802	5,462	17,730					
Balance Forward Out	50		4,671					
Expenditures	**680,359**	**703,153**	**699,041**	**447,444**	**999,168**	**703,444**	**1,015,210**	**1,613,552**
DHS Federal Admin Reimbursement	(15,931)	(15,371)	(17,049)	(17,049)	(17,049)	(17,049)	(17,654)	(18,261)

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures after Federal Admin Reimbursement	**664,428**	**687,782**	**681,992**	**430,395**	**982,119**	**686,395**	**997,556**	**1,595,291**
Biennial Change in Expenditures				(239,824)		556,127		1,480,460
Biennial % Change in Expenditures				(18)		50		133
Governor's Change from Base								924,333
Governor's % Change from Base								55
Full-Time Equivalents	332.69	310.24	296.72	296.72	256.48	251.38	262.19	262.19

2400 - Endowment

Balance Forward In	64	65	65	65	66	67	66	67
Receipts	1	0	0	1	1	1	1	1
Balance Forward Out	65	65	65	66	67	68	67	68

2403 - Gift

Balance Forward In	74	75	403	407	400	397	400	397
Receipts	4	1,213	4	29	29	29	29	29
Transfers In		10						
Transfers Out		10						
Balance Forward Out	75	399	406	400	397	394	397	394
Expenditures	**3**	**889**	**1**	**36**	**32**	**32**	**32**	**32**
Biennial Change in Expenditures				(855)		27		27
Biennial % Change in Expenditures				(96)		71		71
Governor's Change from Base								0
Governor's % Change from Base								0

3000 - Federal

Balance Forward In	487,789	313,253	261,234	233,021	231,597	231,597	231,597	231,597
Receipts	9,952,953	11,487,719	14,273,398	16,671,204	15,333,789	15,262,406	15,355,789	15,277,732
Transfers In	50		16					
Transfers Out	50		16					
Balance Forward Out	357,812	249,524	233,022	231,597	231,597	231,597	231,597	231,597
Expenditures	**10,082,930**	**11,551,448**	**14,301,610**	**16,672,628**	**15,333,789**	**15,262,406**	**15,355,789**	**15,277,732**
Biennial Change in Expenditures				9,339,860		(378,043)		(340,717)
Biennial % Change in Expenditures				43		(1)		(1)

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Governor's Change from Base								37,326
Governor's % Change from Base								0
Full-Time Equivalents	216.90	218.62	241.53	249.48	295.33	287.91	295.33	287.91

3001 - Federal TANF

Balance Forward In	60,907	97,715	142,023	230,094	224,907	210,384	224,907	208,980
Receipts	260,737	261,026	260,679	261,026	261,026	261,026	261,026	261,026
Balance Forward Out	92,800	139,004	220,478	224,907	210,384	195,469	208,980	188,312
Expenditures	**228,844**	**219,737**	**182,224**	**266,213**	**275,549**	**275,941**	**276,953**	**281,694**
Biennial Change in Expenditures				(144)		103,053		110,210
Biennial % Change in Expenditures				(0)		23		25
Governor's Change from Base								7,157
Governor's % Change from Base								1
Full-Time Equivalents	16.30	16.50	13.85	13.85	16.13	15.80	19.91	19.90

3010 - Coronavirus Relief

Balance Forward In		763	5,033					
Direct Appropriation	24,162	281,075	22,040					
Transfers In		5,764						
Transfers Out		5,024						
Cancellations		14,724	2,750					
Balance Forward Out	105	4,167						
Expenditures	**24,057**	**263,686**	**24,323**					
Biennial Change in Expenditures				(263,420)		(24,323)		(24,323)
Biennial % Change in Expenditures				(92)				
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents		2.28	0.05					

3015 - ARP-State Fiscal Recovery

Balance Forward In				2,827				
Direct Appropriation			117,871	27,170	0	0	0	0
Cancellations			131					

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Balance Forward Out			2,827					
Expenditures			**114,913**	**29,997**				
Biennial Change in Expenditures				144,910		(144,910)		(144,910)
Biennial % Change in Expenditures						(100)		(100)
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents			0.48	1.65				

4100 - SOS TBI & Adol Ent Svcs

Balance Forward In	302	542	432	155	183	189	183	189
Receipts	1,670	1,171	565	804	804	804	804	804
Balance Forward Out	540	431	155	183	189	180	189	180
Expenditures	**1,432**	**1,281**	**841**	**776**	**798**	**813**	**798**	**813**
Biennial Change in Expenditures				(1,096)		(6)		(6)
Biennial % Change in Expenditures				(40)		(0)		(0)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	21.40	18.07	10.17	13.20	13.20	13.20	13.20	13.20

4101 - DHS Chemical Dependency Servs

Balance Forward In	2,469	1,778	1,211	80				
Receipts	9,119	8,082	6,684	9,799	10,283	10,560	(9,032)	(9,032)
Transfers In	6,438	7,438	8,438	9,032	9,032	9,032	9,032	9,032
Balance Forward Out	1,648	1,097	80					
Expenditures	**16,378**	**16,202**	**16,252**	**18,911**	**19,315**	**19,592**	**0**	**0**
Biennial Change in Expenditures				2,584		3,744		(35,163)
Biennial % Change in Expenditures				8		11		(100)
Governor's Change from Base								(38,907)
Governor's % Change from Base								(100)
Full-Time Equivalents	141.33	139.37	130.13	150.15	150.15	150.15	150.15	150.15

4350 - MN State Operated Comm Svcs

Balance Forward In	6,396	9,056	15,737	31,367	35,735	37,693	35,735	37,693

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Receipts	102,895	120,865	131,364	134,112	135,453	136,808	135,453	136,808
Transfers In	11,697		6,122	8,503	8,503	8,503	8,503	8,503
Balance Forward Out	8,992	15,613	31,367	35,735	37,693	38,430	37,693	38,430
Expenditures	**111,996**	**114,308**	**121,856**	**138,247**	**141,998**	**144,574**	**141,998**	**144,574**
Biennial Change in Expenditures				33,798		26,469		26,469
Biennial % Change in Expenditures				15		10		10
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	1,369.51	1,312.14	1,272.84	1,302.34	1,302.34	1,302.34	1,302.34	1,302.34

4503 - Minnesota State Industries

Balance Forward In	2,286	2,702	2,967	2,693	2,156	1,619	2,156	1,619
Receipts	1,502	875	1,102	870	870	870	870	870
Balance Forward Out	2,625	2,838	2,693	2,156	1,619	1,082	1,619	1,082
Expenditures	**1,164**	**738**	**1,376**	**1,407**	**1,407**	**1,407**	**1,407**	**1,407**
Biennial Change in Expenditures				881		31		31
Biennial % Change in Expenditures				46		1		1
Governor's Change from Base								0
Governor's % Change from Base								0

4800 - Lottery

Balance Forward In		62		87				
Direct Appropriation	1,896	1,896	1,896	1,896	1,896	1,896	1,896	1,896
Open Appropriation	1	0	1					
Cancellations	282	130	139					
Balance Forward Out	62		87					
Expenditures	**1,553**	**1,828**	**1,670**	**1,983**	**1,896**	**1,896**	**1,896**	**1,896**
Biennial Change in Expenditures				272		139		139
Biennial % Change in Expenditures				8		4		4
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	1.08	1.00	0.80	0.80	1.33	1.31	1.33	1.31

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
4925 - Paid Family Medical Leave								
Direct Appropriation							2,649	
Expenditures							**2,649**	
Biennial Change in Expenditures				0		0		2,649
Biennial % Change in Expenditures								
Governor's Change from Base								2,649
Governor's % Change from Base								
6000 - Miscellaneous Agency								
Balance Forward In	4,612	4,698	6,075	7,272	7,310	7,348	7,310	7,348
Receipts	16,648	14,004	12,494	215,147	215,147	215,147	215,147	215,147
Transfers Out		0						
Balance Forward Out	4,401	5,850	7,272	7,310	7,348	7,386	7,348	7,386
Expenditures	**16,859**	**12,852**	**11,297**	**215,109**	**215,109**	**215,109**	**215,109**	**215,109**
Biennial Change in Expenditures				196,695		203,812		203,812
Biennial % Change in Expenditures				662		90		90
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	1.16	0.69	0.55	0.55	0.06	0.06	0.06	0.06
6003 - Child Support Enforcement								
Balance Forward In	9,695	20,037	12,104	9,586	17,726	25,866	17,726	25,866
Receipts	626,121	581,786	547,126	650,095	650,095	650,095	650,095	650,095
Balance Forward Out	20,037	12,104	9,586	17,726	25,866	34,006	25,866	34,006
Expenditures	**615,778**	**589,719**	**549,644**	**641,955**	**641,955**	**641,955**	**641,955**	**641,955**
Biennial Change in Expenditures				(13,898)		92,311		92,311
Biennial % Change in Expenditures				(1)		8		8
Governor's Change from Base								0
Governor's % Change from Base								0

(Dollars in Thousands)

	FY23	FY24	FY25	Biennium 2024-25
Direct				
Fund: 1000 - General				
FY2023 Appropriations	**9,160,430**	**9,160,430**	**9,160,430**	**18,320,860**
Base Adjustments				
All Other One-Time Appropriations		(5,138)	(5,138)	(10,276)
Current Law Base Change		(278,065)	249,280	(28,785)
Approved Transfer Between Appropriation		0	0	0
November Forecast Adjustment	(1,157,816)	(349,640)	(370,292)	(719,932)
February Forecast Adjustment	(77,272)	(51,475)	54,627	3,152
Forecast Base	**7,925,342**	**8,476,112**	**9,088,907**	**17,565,019**
Change Items				
Community First Services and Supports Rate Framework Investments		121,404	177,697	299,101
Child Care Assistance Program (CCAP) Maximum Rate Update		21,698	95,253	116,951
Expanding Medical Assistance Coverage for Children		2,257	19,421	21,678
Older Adult Long Term Care Workforce		6,148	34,865	41,013
Addressing Deep Poverty for Minnesotans with Disabilities and Disabling Conditions		185	21,474	21,659
Increasing Wages and Workforce Participation for People with Disabilities		2,199	6,448	8,647
Critical Resources for Licensing		8,170	9,457	17,627
Addressing Homelessness for Minnesota Adults, Youth, and Families		26,206	31,415	57,621
Direct Care and Treatment as a Separate Agency		4,384	4,088	8,472
Service Delivery Transformation		15,518	14,058	29,576
Child Care Assistance Program Basic Sliding Fee Investments		15,000	15,000	30,000
Supporting the Child Care Industry and Workforce		172,942	176,137	349,079
Supporting Working Minnesotans		704	1,578	2,282
Family First Prevention Services Act (FFPSA) Phase 3 and Operational Investments		14,222	22,198	36,420
Supporting Tribal Child Welfare Agencies and the American Indian Child Welfare Initiative		9,950	11,931	21,881
Food Security for Minnesota Families		33,141	13,570	46,711
Support After Foster Care		9,040	9,413	18,453
New Non-Caregiver Sex Trafficking Response Path		85	17	102
Employment and Income Verification for Public Assistance Programs		1,000	1,000	2,000
Expanding Child Care Supports for Foster Care and Relative Caregivers		89	12,256	12,345
Building Assets for Minnesota Families		1,527	2,822	4,349
Medical Assistance Coverage for Former Foster Care Youth from Other States		1,512	728	2,240
Child Support Improvements and Investments		218	268	486
Administrative Improvements for Child Care Providers		678	647	1,325
Integrated Services for Children and Families		16,841	12,519	29,360
Community Resource Centers		2,211	14,223	16,434
Preserving American Indian Families		6,733	7,106	13,839

(Dollars in Thousands)

	FY23	FY24	FY25	Biennium 2024-25
Workforce Sustainability for People who Live in Their Own Homes		8,642	22,655	31,297
Data-based Rates for Residential and Own Home Disability Services		8,858	68,370	77,228
Critical Access Nursing Facilities (CANF)		913	1,000	1,913
Planning for Innovative & Community-Driven Workforce Solutions		1,050	1,388	2,438
Supporting Transitions for Small Customized Living Providers		1,016	1,952	2,968
Capacity and Workforce Expansion Programs		6,612	26,952	33,564
Vulnerable Adult Act Redesign - Phase 2		12,445	13,580	26,025
Improving the MA Experience for People with Disabilities		6,417	4,017	10,434
Tribal Elder Office		834	971	1,805
EIDBI Culturally Responsive Rate & Licensure Study		349	376	725
Improving Assessment Experiences for People and Lead Agencies		2,236	2,497	4,733
Nursing Facility Case Mix Classification Modification		82	35	117
Technology Investments to Support Independent Living and Address HCBS Workforce Challenges		352	405	757
Improving Access to Behavioral Health Services		11,795	18,039	29,834
Mental Health Crisis and Early Intervention Service Expansion		10,692	14,861	25,553
Reducing Disparities and Addressing the Opioid Epidemic		28,066	18,683	46,749
Expediting Access to Behavioral Health Services		13,835	18,213	32,048
Improving Quality of Substance Use Disorder Treatment & Alleviating Administrative Burdens		1,549	1,748	3,297
Sustaining the Behavioral Health Workforce		17,870	18,000	35,870
Reforming Behavioral Health Peer Support Benefits		2,468	4,940	7,408
Sober Housing Program Regulation and Consumer Protections		277	322	599
Medical Assistance Substance Use Disorder Continuum		1,895	1,959	3,854
Advancing Independence & Housing Stability: Improvements to Housing Stabilization Services		3,911	8,683	12,594
Strengthening Adult Income Supports		1,207	4,644	5,851
Reducing Recidivism through Evidence-Based Community Housing Interventions		853	1,925	2,778
Increasing Health Care Access for Minnesotans		10,032	4,312	14,344
Increasing Access to Health Insurance for Minnesotans		9,255	8,167	17,422
Supporting Tribal Providers and Payments		903	1,006	1,909
Improving the Minnesota Eligibility Technology System (METS) Functionality		18,063	711	18,774
Responding to COVID-19 in Minnesota Health Care Programs		64,297	1,323	65,620
Improving Program Integrity in Minnesota Health Care Programs		1,179	1,246	2,425
Continued Improvements to Access to Oral Health		6,179	14,686	20,865
Remove Doula Supervision Requirements		33	40	73
Elimination of Medical Assistance Cost-sharing		3,051	6,156	9,207
MA-EPD Program Improvements and Conforming Changes		208	42	250
Newborn Screening Fee Increase Technical Fix		3	4	7
Ensuring Access to Health Care Services		2,283	5,381	7,664
Streamlining Behavioral Health Regulation		1,947	1,022	2,969
Drug Formulary Committee (DFC) Modifications		(20,199)	(39,333)	(59,532)

(Dollars in Thousands)

	FY23	FY24	FY25	Biennium 2024-25
Supporting Health Care Coverage and Transitions in Care for Urban Indians		2,533	2,538	5,071
Preserving Funding for Medical Education and Research Costs		15,158	18,382	33,540
Innovations in Healthcare Purchasing		744	2,518	3,262
Value-Based Arrangements for Drug Purchasing		372	406	778
Establishing Medicaid Sanctionable Behavior Standards for Unsafe Opioid Prescribing Practices		200	200	400
Rate Increase for Reproductive Health Services in Minnesota Health Care Programs		132	301	433
Medicaid Management Information System Modernization		14,141		14,141
Use of Audio-Only Telehealth in Minnesota Health Care Programs		6,197	8,153	14,350
Direct Care and Treatment Maintain Current Service Levels		57,813	81,456	139,269
Direct Care and Treatment Electronic Health Record System		6,680	19,241	25,921
Direct Care and Treatment Program Enhancements		8,009	8,009	16,018
DHS Central Office Maintain Current Service Levels		18,291	29,438	47,729
Continuous Improvement and Compliance Expansion		2,962	5,968	8,930
Provider Licensing and Reporting Hub		12,199	6,334	18,533
Background Studies Operations		1,773	2,638	4,411
Background Studies Fee Changes		52	52	104
Fraud Prevention Investments for Tribal Nations		541	165	706
Modernize Adult Residential Mental Health Rule		194	318	512
Family Child Care Continuous Licenses		708		708
Financial Fraud and Abuse Investigations (FFAID) Program Integrity Enhancements		1,024	1,047	2,071
New Chapter for Public Law Background Studies		250		250
Background Studies 245C Statutory Changes		601	395	996
Census Income Exclusion For Benefits		66	13	79
Easy Enrollment		505	579	1,084
Technology Modernization		1,895	1,950	3,845
Legalizing Adult-Use Cannabis		3,324	7,641	10,965
Increase the Health Care Access Fund Appropriation for Medical Assistance			(897,400)	(897,400)
Acute Care Transitions: Building Statewide Capacity		24,533	4,637	29,170
Addressing the HIV epidemic in Minnesota		12,100		12,100
Department of Children, Youth, and Families Created to Coordinate and Improve Program Delivery		2,941		2,941
Direct Care and Treatment FY2023 Operating Deficiency	4,829			
MA Enteral Feeding Product Rate Methodology Change		830	2,399	3,229
Hospice Respite and End-of-Life Care for Children on MA		64	95	159
MFIP Sanction Reform and Housing Assistance		1,115	2,134	3,249
Supporting Children and Families		316	63	379
Ombudsperson for Long Term Care Staffing		500	500	1,000
Total Governor's Recommendations	**7,930,171**	**9,410,395**	**9,375,644**	**18,786,039**
Fund: 1200 - State Government Special Rev				

(Dollars in Thousands)

	FY23	FY24	FY25	Biennium 2024-25
FY2023 Appropriations	**4,299**	**4,299**	**4,299**	**8,598**
Forecast Base	**4,299**	**4,299**	**4,299**	**8,598**
Change Items				
DHS Central Office Maintain Current Service Levels		268	536	804
Home and Community-Based Services Corporate License Application Fee		740	740	1,480
Total Governor's Recommendations	**4,299**	**5,307**	**5,575**	**10,882**
Fund: 1201 - Health Related Boards				
FY2023 Appropriations	**522**	**522**	**522**	**1,044**
Base Adjustments				
Current Law Base Change		(188)	52	(136)
Forecast Base	**522**	**334**	**574**	**908**
Total Governor's Recommendations	**522**	**334**	**574**	**908**
Fund: 2005 - Opiate Epidemic Response				
FY2023 Appropriations	**30,065**	**30,065**	**30,065**	**60,130**
Base Adjustments				
Current Law Base Change	4,790	(21,930)	(11,619)	(33,549)
Forecast Base	**34,855**	**8,135**	**18,446**	**26,581**
Change Items				
Reducing Disparities and Addressing the Opioid Epidemic		6,646	341	6,987
Medical Assistance Substance Use Disorder Continuum			275	275
Total Governor's Recommendations	**34,855**	**14,781**	**19,062**	**33,843**
Fund: 2360 - Health Care Access				
FY2023 Appropriations	**649,709**	**649,709**	**649,709**	**1,299,418**
Base Adjustments				
Current Law Base Change		538,818	266,105	804,923
Approved Transfer Between Appropriation		0	0	0
November Forecast Adjustment	(196,098)	(189,387)	(206,963)	(396,350)
February Forecast Adjustment	(7,432)	3,990	(1,005)	2,985
Forecast Base	**446,179**	**1,003,130**	**707,846**	**1,710,976**
Change Items				
Increasing Health Care Access for Minnesotans			1,077	1,077
Responding to COVID-19 in Minnesota Health Care Programs		10,265		10,265
Continued Improvements to Access to Oral Health		2,796	6,387	9,183
Rate Increase for Reproductive Health Services in Minnesota Health Care Programs		26	58	84
Use of Audio-Only Telehealth in Minnesota Health Care Programs		1,038	1,339	2,377
DHS Central Office Maintain Current Service Levels		1,891	3,788	5,679
Increase the Health Care Access Fund Appropriation for Medical Assistance			897,400	897,400

(Dollars in Thousands)

	FY23	FY24	FY25	Biennium 2024-25
MA Enteral Feeding Product Rate Methodology Change		26	59	85
Total Governor's Recommendations	**446,179**	**1,019,172**	**1,617,954**	**2,637,126**
Fund: 3015 - ARP-State Fiscal Recovery				
FY2023 Appropriations	**27,170**	**27,170**	**27,170**	**54,340**
Base Adjustments				
All Other One-Time Appropriations		(27,170)	(27,170)	(54,340)
Forecast Base	**27,170**	**0**	**0**	**0**
Total Governor's Recommendations	**27,170**	**0**	**0**	**0**
Fund: 4800 - Lottery				
FY2023 Appropriations	**1,896**	**1,896**	**1,896**	**3,792**
Base Adjustments				
Current Law Base Change		0	0	0
Forecast Base	**1,896**	**1,896**	**1,896**	**3,792**
Total Governor's Recommendations	**1,896**	**1,896**	**1,896**	**3,792**
Fund: 4925 - Paid Family Medical Leave				
Change Items				
Paid Family and Medical Leave Insurance		2,649		2,649
Total Governor's Recommendations		**2,649**		**2,649**
Open				
Fund: 2360 - Health Care Access				
FY2023 Appropriations	**158**	**158**	**158**	**316**
Base Adjustments				
Forecast Open Appropriation Adjustment	61	61	61	122
Forecast Base	**219**	**219**	**219**	**438**
Total Governor's Recommendations	**219**	**219**	**219**	**438**
Dedicated				
Fund: 1000 - General				
Planned Spending	**4,673**	**2,101**	**2,206**	**4,307**
Forecast Base	**4,673**	**2,101**	**2,206**	**4,307**
Total Governor's Recommendations	**4,673**	**2,101**	**2,206**	**4,307**
Fund: 2000 - Restrict Misc Special Revenue				
Planned Spending	**152,823**	**150,732**	**150,828**	**301,560**
Forecast Base	**152,823**	**150,732**	**150,828**	**301,560**

(Dollars in Thousands)

	FY23	FY24	FY25	Biennium 2024-25
Change Items				
Direct Care and Treatment Program Enhancements		(1,451)	(1,451)	(2,902)
Background Studies Fee Changes		570	606	1,176
Total Governor's Recommendations	**152,823**	**149,851**	**149,983**	**299,834**
Fund: 2001 - Other Misc Special Revenue				
Planned Spending	**645,003**	**540,266**	**528,949**	**1,069,215**
Forecast Base	**645,003**	**540,266**	**528,949**	**1,069,215**
Change Items				
Child Support Improvements and Investments		64	32	96
Total Governor's Recommendations	**645,003**	**540,330**	**528,981**	**1,069,311**
Fund: 2360 - Health Care Access				
Planned Spending	**5,886**	**5,329**	**4,889**	**10,218**
Forecast Base	**5,886**	**5,329**	**4,889**	**10,218**
Total Governor's Recommendations	**5,886**	**5,329**	**4,889**	**10,218**
Fund: 2403 - Gift				
Planned Spending	**36**	**32**	**32**	**64**
Forecast Base	**36**	**32**	**32**	**64**
Total Governor's Recommendations	**36**	**32**	**32**	**64**
Fund: 3000 - Federal				
Planned Spending	**16,672,628**	**15,333,789**	**15,262,406**	**30,596,195**
Forecast Base	**16,672,628**	**15,333,789**	**15,262,406**	**30,596,195**
Change Items				
Child Care Assistance Program (CCAP) Maximum Rate Update		22,000	8,000	30,000
Permanent Reprioritization of the Child Care Assistance Program Basic sliding Fee			7,824	7,824
Expanding Child Care Supports for Foster Care and Relative Caregivers			(498)	(498)
Total Governor's Recommendations	**16,672,628**	**15,355,789**	**15,277,732**	**30,633,521**
Fund: 3001 - Federal TANF				
Planned Spending	**266,213**	**275,549**	**275,941**	**551,490**
Forecast Base	**266,213**	**275,549**	**275,941**	**551,490**
Change Items				
Supporting Working Minnesotans			1,402	1,402
DHS Central Office Maintain Current Service Levels		990	1,094	2,084
MFIP Sanction Reform and Housing Assistance		414	3,257	3,671
Total Governor's Recommendations	**266,213**	**276,953**	**281,694**	**558,647**

(Dollars in Thousands)

	FY23	FY24	FY25	Biennium 2024-25
Fund: 4100 - SOS TBI & Adol Ent Svcs				
Planned Spending	**776**	**798**	**813**	**1,611**
Forecast Base	**776**	**798**	**813**	**1,611**
Total Governor's Recommendations	**776**	**798**	**813**	**1,611**
Fund: 4101 - DHS Chemical Dependency Servs				
Planned Spending	**18,911**	**19,315**	**19,592**	**38,907**
Forecast Base	**18,911**	**19,315**	**19,592**	**38,907**
Change Items				
Direct Care and Treatment Program Enhancements		(19,315)	(19,592)	(38,907)
Total Governor's Recommendations	**18,911**	**0**	**0**	**0**
Fund: 4350 - MN State Operated Comm Svcs				
Planned Spending	**138,247**	**141,998**	**144,574**	**286,572**
Forecast Base	**138,247**	**141,998**	**144,574**	**286,572**
Total Governor's Recommendations	**138,247**	**141,998**	**144,574**	**286,572**
Fund: 4503 - Minnesota State Industries				
Planned Spending	**1,407**	**1,407**	**1,407**	**2,814**
Forecast Base	**1,407**	**1,407**	**1,407**	**2,814**
Total Governor's Recommendations	**1,407**	**1,407**	**1,407**	**2,814**
Fund: 6000 - Miscellaneous Agency				
Planned Spending	**215,109**	**215,109**	**215,109**	**430,218**
Forecast Base	**215,109**	**215,109**	**215,109**	**430,218**
Total Governor's Recommendations	**215,109**	**215,109**	**215,109**	**430,218**
Fund: 6003 - Child Support Enforcement				
Planned Spending	**641,955**	**641,955**	**641,955**	**1,283,910**
Forecast Base	**641,955**	**641,955**	**641,955**	**1,283,910**
Total Governor's Recommendations	**641,955**	**641,955**	**641,955**	**1,283,910**
DHS Federal Admin Reimbursement				
Fund: 1000 - General				
Forecast Federal Administrative Reimbursement	**(44,637)**	**(44,853)**	**(44,838)**	**(89,691)**
Change Items				
Community First Services and Supports Rate Framework Investments		(451)	(743)	(1,194)
Child Care Assistance Program (CCAP) Maximum Rate Update		(43)	(49)	(92)
Expanding Medical Assistance Coverage for Children			(379)	(379)
Older Adult Long Term Care Workforce		(159)	(264)	(423)

(Dollars in Thousands)

	FY23	FY24	FY25	Biennium 2024-25
Increasing Wages and Workforce Participation for People with Disabilities		(248)	(423)	(671)
Critical Resources for Licensing		(2,614)	(3,026)	(5,640)
Addressing Homelessness for Minnesota Adults, Youth, and Families		(428)	(495)	(923)
Direct Care and Treatment as a Separate Agency		(320)	(320)	(640)
Supporting the Child Care Industry and Workforce		(2,270)	(1,911)	(4,181)
Family First Prevention Services Act (FFPSA) Phase 3 and Operational Investments		(1,171)	(1,323)	(2,494)
Supporting Tribal Child Welfare Agencies and the American Indian Child Welfare Initiative		(45)	(53)	(98)
Food Security for Minnesota Families		(685)	(502)	(1,187)
Support After Foster Care		(612)	(495)	(1,107)
Building Assets for Minnesota Families		(89)	(103)	(192)
Medical Assistance Coverage for Former Foster Care Youth from Other States		(144)	(165)	(309)
Administrative Improvements for Child Care Providers		(45)	(180)	(225)
Integrated Services for Children and Families		(1,515)	(1,709)	(3,224)
Community Resource Centers		(707)	(694)	(1,401)
Preserving American Indian Families		(745)	(864)	(1,609)
Workforce Sustainability for People who Live in Their Own Homes		(686)	(871)	(1,557)
Data-based Rates for Residential and Own Home Disability Services			(57)	(57)
Planning for Innovative & Community-Driven Workforce Solutions		(215)	(324)	(539)
Supporting Transitions for Small Customized Living Providers		(107)	(124)	(231)
Capacity and Workforce Expansion Programs		(516)	(760)	(1,276)
Vulnerable Adult Act Redesign - Phase 2		(399)	(527)	(926)
Improving the MA Experience for People with Disabilities		(860)	(1,047)	(1,907)
Tribal Elder Office		(267)	(311)	(578)
EIDBI Culturally Responsive Rate & Licensure Study		(110)	(113)	(223)
Improving Assessment Experiences for People and Lead Agencies		(279)	(277)	(556)
Improving Access to Behavioral Health Services		(919)	(1,147)	(2,066)
Mental Health Crisis and Early Intervention Service Expansion		(349)	(404)	(753)
Reducing Disparities and Addressing the Opioid Epidemic		(810)	(968)	(1,778)
Expediting Access to Behavioral Health Services		(457)	(530)	(987)
Improving Quality of Substance Use Disorder Treatment & Alleviating Administrative Burdens		(491)	(558)	(1,049)
Sustaining the Behavioral Health Workforce		(262)	(304)	(566)
Reforming Behavioral Health Peer Support Benefits		(136)	(180)	(316)
Sober Housing Program Regulation and Consumer Protections		(89)	(103)	(192)
Medical Assistance Substance Use Disorder Continuum		(373)	(275)	(648)
Advancing Independence & Housing Stability: Improvements to Housing Stabilization Services		(416)	(909)	(1,325)
Strengthening Adult Income Supports		(45)	(53)	(98)
Reducing Recidivism through Evidence-Based Community Housing Interventions		(36)	(98)	(134)
Increasing Health Care Access for Minnesotans		(983)	(949)	(1,932)

(Dollars in Thousands)

	FY23	FY24	FY25	Biennium 2024-25
Supporting Tribal Providers and Payments		(263)	(305)	(568)
Improving the Minnesota Eligibility Technology System (METS) Functionality		(513)	(228)	(741)
Responding to COVID-19 in Minnesota Health Care Programs		(6,807)	(259)	(7,066)
Improving Program Integrity in Minnesota Health Care Programs		(208)	(208)	(416)
Continued Improvements to Access to Oral Health		(4)	(8)	(12)
Ensuring Access to Health Care Services		(8)	(8)	(16)
Streamlining Behavioral Health Regulation		(88)	(102)	(190)
Drug Formulary Committee (DFC) Modifications		(3)	(3)	(6)
Supporting Health Care Coverage and Transitions in Care for Urban Indians		(11)	(12)	(23)
Innovations in Healthcare Purchasing		(238)	(330)	(568)
Value-Based Arrangements for Drug Purchasing		(119)	(130)	(249)
Establishing Medicaid Sanctionable Behavior Standards for Unsafe Opioid Prescribing Practices		(64)	(64)	(128)
DHS Central Office Maintain Current Service Levels		(3,113)	(5,701)	(8,814)
Continuous Improvement and Compliance Expansion		(916)	(1,860)	(2,776)
Provider Licensing and Reporting Hub		(1,115)	(1,085)	(2,200)
Background Studies Operations		(567)	(844)	(1,411)
Fraud Prevention Investments for Tribal Nations		(45)	(53)	(98)
Modernize Adult Residential Mental Health Rule		(62)	(102)	(164)
Financial Fraud and Abuse Investigations (FFAID) Program Integrity Enhancements		(287)	(334)	(621)
New Chapter for Public Law Background Studies		(80)		(80)
Background Studies 245C Statutory Changes		(192)	(126)	(318)
Easy Enrollment		(162)	(185)	(347)
Technology Modernization		(299)	(325)	(624)
Legalizing Adult-Use Cannabis		(1,064)	(1,165)	(2,229)
Acute Care Transitions: Building Statewide Capacity		(1,011)	(1,319)	(2,330)
Department of Children, Youth, and Families Created to Coordinate and Improve Program Delivery		(941)		(941)
MFIP Sanction Reform and Housing Assistance		(125)	(144)	(269)
Total Governor's Recommendations	**(44,637)**	**(84,254)**	**(84,325)**	**(168,579)**
Fund: 2360 - Health Care Access				
Forecast Federal Administrative Reimbursement	**(17,049)**	**(17,049)**	**(17,049)**	**(34,098)**
Change Items				
DHS Central Office Maintain Current Service Levels		(605)	(1,212)	(1,817)
Total Governor's Recommendations	**(17,049)**	**(17,654)**	**(18,261)**	**(35,915)**
Revenue Change Summary				
Dedicated				
Fund: 1000 - General				

(Dollars in Thousands)

	FY23	FY24	FY25	Biennium 2024-25
Forecast Revenues	**1,959**	**2,101**	**2,206**	**4,307**
Total Governor's Recommendations	**1,959**	**2,101**	**2,206**	**4,307**
Fund: 2000 - Restrict Misc Special Revenue				
Forecast Revenues	**148,111**	**144,895**	**148,079**	**292,974**
Change Items				
Direct Care and Treatment Program Enhancements		(1,451)	(1,451)	(2,902)
Background Studies Fee Changes		570	606	1,176
Total Governor's Recommendations	**148,111**	**144,014**	**147,234**	**291,248**
Fund: 2001 - Other Misc Special Revenue				
Forecast Revenues	**414,820**	**322,699**	**314,714**	**637,413**
Total Governor's Recommendations	**414,820**	**322,699**	**314,714**	**637,413**
Fund: 2360 - Health Care Access				
Forecast Revenues	**5,885**	**5,329**	**4,889**	**10,218**
Total Governor's Recommendations	**5,885**	**5,329**	**4,889**	**10,218**
Fund: 2400 - Endowment				
Forecast Revenues	**1**	**1**	**1**	**2**
Total Governor's Recommendations	**1**	**1**	**1**	**2**
Fund: 2403 - Gift				
Forecast Revenues	**29**	**29**	**29**	**58**
Total Governor's Recommendations	**29**	**29**	**29**	**58**
Fund: 3000 - Federal				
Forecast Revenues	**16,671,204**	**15,333,789**	**15,262,406**	**30,596,195**
Change Items				
Child Care Assistance Program (CCAP) Maximum Rate Update		22,000	8,000	30,000
Permanent Reprioritization of the Child Care Assistance Program Basic sliding Fee			7,824	7,824
Expanding Child Care Supports for Foster Care and Relative Caregivers			(498)	(498)
Total Governor's Recommendations	**16,671,204**	**15,355,789**	**15,277,732**	**30,633,521**
Fund: 3001 - Federal TANF				
Forecast Revenues	**261,026**	**261,026**	**261,026**	**522,052**
Change Items				
DHS Central Office Maintain Current Service Levels		0	0	0
Total Governor's Recommendations	**261,026**	**261,026**	**261,026**	**522,052**

(Dollars in Thousands)

	FY23	FY24	FY25	Biennium 2024-25
Fund: 4100 - SOS TBI & Adol Ent Svcs				
Forecast Revenues	**804**	**804**	**804**	**1,608**
Total Governor's Recommendations	**804**	**804**	**804**	**1,608**
Fund: 4101 - DHS Chemical Dependency Servs				
Forecast Revenues	**9,799**	**10,283**	**10,560**	**20,843**
Change Items				
Direct Care and Treatment Program Enhancements		(19,315)	(19,592)	(38,907)
Total Governor's Recommendations	**9,799**	**(9,032)**	**(9,032)**	**(18,064)**
Fund: 4350 - MN State Operated Comm Svcs				
Forecast Revenues	**134,112**	**135,453**	**136,808**	**272,261**
Total Governor's Recommendations	**134,112**	**135,453**	**136,808**	**272,261**
Fund: 4503 - Minnesota State Industries				
Forecast Revenues	**870**	**870**	**870**	**1,740**
Total Governor's Recommendations	**870**	**870**	**870**	**1,740**
Fund: 6000 - Miscellaneous Agency				
Forecast Revenues	**215,147**	**215,147**	**215,147**	**430,294**
Total Governor's Recommendations	**215,147**	**215,147**	**215,147**	**430,294**
Fund: 6003 - Child Support Enforcement				
Forecast Revenues	**650,095**	**650,095**	**650,095**	**1,300,190**
Total Governor's Recommendations	**650,095**	**650,095**	**650,095**	**1,300,190**
Non-Dedicated				
Fund: 1000 - General				
Forecast Revenues	**478,718**	**475,530**	**487,395**	**962,925**
Change Items				
Direct Care and Treatment Maintain Current Service Levels		16,539	23,052	39,591
Direct Care and Treatment Program Enhancements		8,009	8,009	16,018
Total Governor's Recommendations	**478,718**	**500,078**	**518,456**	**1,018,534**
Fund: 1200 - State Government Special Rev				
Forecast Revenues	**5,469**	**5,469**	**5,469**	**10,938**
Change Items				
Home and Community-Based Services Corporate License Application Fee		740	740	1,480
Total Governor's Recommendations	**5,469**	**6,209**	**6,209**	**12,418**

Change Item Title: Community First Services and Supports (CFSS) Rate Framework Investments

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	120,953	176,954	237,361	240,761
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	120,953	176,954	237,361	240,761
FTEs	**12**	**16**	**14**	**14**

Recommendation:

The Governor recommends investments in Minnesota's Personal Care Assistance (PCA)/ Community First Services and Supports (CFSS) program to help address the unprecedented challenges the state is experiencing in attracting and retaining quality staff needed to support people in their homes and community. This proposal does the following:

- Invest in rate increases, retention bonuses, and paid time off for PCA/CFSS workers;
- Develop career ladders with corresponding tiered rates so workers can advance in their careers and be more willing to join and stay in the workforce;
- Provide necessary administrative funds to cover expenses related to the SEIU bargaining agreement;
- Provide funding for provider training stipends and provider orientation;
- Allow for two person cares PCA/CFSS cares; and
- Clarify that home care nursing will be authorized in the same manner it is now, once CFSS is implemented.

Investments in this proposal total $298 million in fiscal years 2024-25 and $478 million in fiscal years 2026-27.

Rationale/Background:

Personal Care Assistance services were first offered in Minnesota in 1977 when they were added to the Medical Assistance (MA) state plan as an optional Medicaid service (MA is Minnesota's Medicaid program). At that time, the program was fairly limited and was only available to adults with physical disabilities. Since then, the legislature has expanded access to the program to include children, older adults with disabilities, and people with chronic diseases, behavioral diagnoses, and mental illness who have functional limitations that effect their daily activities.

PCA services assist people with daily activities (such as eating, bathing, and dressing), as well as behavioral support activities and other health-related tasks. With the assistance of trained and reliable staff, PCA enables people to be more independent in their home, job, and community, and can prevent or delay more intensive, costly services. Community First Services and Supports (CFSS) is a new home and community-based service pending federal approval to assist people with daily activities. CFSS is similar to PCA, but it will offer enhanced options for people who wish to self-direct services, will allow people to purchase goods and services, will provide consultation services to help people with person-centered planning, and it will allow parents of minors and spouses to be reimbursed to provide services. When implemented, CFSS will replace the PCA and Consumer Support Grant (CSG) programs. It will cover all eligibility categories currently covered by PCA.

In state fiscal year 2020, about 44,000 people received PCA services through the fee-for-service and managed care programs. However, people enter and exit the program throughout the year. The average monthly caseload, which is a good measure of how many people are using PCA at any one time, was about 36,000 people. The PCA

program is one of the most diverse long-term service and support programs in Minnesota and has been growing more diverse over time. In January of 2020, 62% of program participants were people of color or Native American. Approximately 30% of PCA recipients were non-Hispanic white, compared to an estimated 80% of Minnesotans statewide. In State Fiscal Year 2020, the total Medical Assistance expenditures for state plan PCA services were about $1.08 billion dollars, including both state and federal shares. Between 2016 and 2020, total expenditures increased at an average annual rate of 5.2%.

The availability of qualified direct care staff is the foundation of home and community-based services that help people live and work in their homes and communities. As the demand for long-term services and supports grows with drastically shifting demographics, there is a corresponding change in the number of working-age people entering the workforce. Additionally, the supply of direct care staff decreases with better economic conditions.

The direct care workforce is not keeping pace with the growing demand of an aging population and people with disabilities who need support services. In 2018, the University of Minnesota Institute on Community Integration estimated that there were 204,000 people providing direct support services and 27,540 direct support job vacancies (13.5% vacancy rate). Minnesota is currently experiencing an unprecedented workforce shortage in the long term care sector. While job vacancies in Minnesota are at record highs across all sectors, healthcare and social assistance sectors have the most severe workforce shortages, with more than 52,000 vacancies in the fourth quarter of 2021. These vacancies increased by 66 percent in just one year and within that sector, Personal Care & Service vacancies increased by more than 225% over the year.

While other industries may have the capacity to be agile in responding to changing economic conditions, the direct care industry is heavily reliant on human capital and the majority of their revenue is dependent on public program payment rates. In many instances, service providers are competing for workers with other industries that are able to offer more incentives, while the job of direct care work may be physically and emotionally demanding.

Historically, PCA services were reimbursed as a single, statewide rate for 15-minute units, subject to unpredictable percentage increases or decreases authorized by the legislature. The service was routinely overlooked when it came to legislative investments with long-term care investments instead favoring disability waiver services. The imbalance in legislative spending has led to underfunding of PCA services that help keep people in their own homes and working in their communities. The 2021 Legislature authorized the establishment of a prospective, research-based PCA rate framework (similar to the DWRS rate framework). They also made a historic investment, increasing PCA rates by over 10%. Despite the recent investments in PCA services, the rate is still 42% lower than comparable DWRS services. Unlike the DWRS rate framework, the PCA rate framework does not have any automatic inflationary and is not fully funded to reimburse providers their reasonable costs associated with delivering the service.

Like other states, Minnesota is experiencing an unprecedented workforce shortage with the most acute impacts on the direct care workforce. A 2018 study conducted by DHS and the Institute on Community Integration at the University of Minnesota found that personal care assistance wages were lower than all other service types surveyed. DHS 2021 labor market reporting data found that PCA wages are often well-below average wages for waiver services, however PCA providers are directing a larger proportion of the rate to wages, compared with waiver providers. The table below illustrates this data.

Service Type	Median full-time wage	Median part-time wage	Direct support worker wage component in DWRS rate
Day Services	$13.50/hr.	$13/hr.	$16.02/hr.
Residential Services	$14.68/hr.	$14.42/hr.	$14.17/hr.
Unit-based Services	$14/hr.	$13.50/hr.	$12.85-$19.16/hr.
PCA Services	$13.25/hr.	$13/hr.	n/a, however PCA providers are required to direct 72.5% of aggregate revenue to worker compensation. Some PCA wages are subject to a wage floor. For comparison, the CBA wage floor for FY 2020-2021 was $13.25/hr.

Slow growing PCA rates have led to an impoverished workforce. Nationally, approximately 45 percent of direct-care workers live in households earning below 200 percent of the federal poverty level income, making them eligible for most public assistance programs. In 2015, over half of homecare workers in the United States relied on some form of public assistance including, food and nutrition assistance, Medicaid, and cash assistance. Approximately 40 percent of homecare workers relied on public health care coverage, most often Medicaid. (Paraprofessional Healthcare Institute, 2017).

Along with low reimbursement rates for PCA/CFSS and the resulting wages workers receive, some workers are hesitant to begin a job as a PCA as there is little room to advance. The legislature has considered proposals in the past to create career ladders for direct care workers, including PCAs and CFSS workers. These proposals encountered implementation barriers related to complex system interactions, built on an outdated IT infrastructure. As part of the 2021-2023 collective bargaining agreement between the State of Minnesota and Service Employees International Union Healthcare Minnesota (SEIU), the State agreed to evaluate options for a wage differential, including reviewing relevant state and federal regulations, as well as providing a written report on its findings by September 1, 2022. The report indicated that DHS would need to determine which differentials are of interest. Wage tiers could be used to achieve certain policy objectives (e.g., staff retention early in their career) or could be set on a standard schedule (e.g., an annual or biannual differential).

Proposal:

Increasing PCA/CFSS rates is expected to increase worker wages thereby reducing staff turnover, increasing hours delivered by people familiar with person's needs, and increasing trust and quality of life by having consistency in personal care. This proposal provides critical investments in the PCA/CFSS programs to ensure people can continue receiving services in their homes and communities, reducing pressures to move into institutional or more restrictive settings. It will also allow for the implementation of the tentative collective bargaining agreement between the State of Minnesota and SEIU Healthcare. This proposal will:

- Invest in rate increases, retention bonuses, and paid time off for PCA/CFSS workers;
- Develop career ladders with corresponding tiered rates so workers can advance in their careers and be more willing to join and stay in the workforce;
- Provide necessary funds to cover expenses arising from labor disputes initiated by SEIU Healthcare;
- Provide funding for provider training stipends and provider orientation;
- Allow for two person cares PCA/CFSS cares; and
- Clarify that home care nursing will be authorized in the same manner it is now, once CFSS is implemented.

Invest in rate increases, retention bonuses, and paid time off for PCA/CFSS workers

Effective January 1, 2024 this provision will increase PCA/CFSS/CSG rates by 16.88% and increase CDCS budgets by 8.49%. Effective January 1, 2025 this provision will further increase PCA/CFSS/CSG rates by a minimum of 5.1%, increasing PCA/CFSS/CSG rates overall by at least 21.98% compared to current law depending on the tiers workers fall in as detailed below. The weighted average rate increase on January 1, 2025 is 27.76 percent compared to current law.

Effective January 1, 2025, this proposal will also further increase CDCS budgets by 4.53%, increasing CDCS budgets overall by 13.06%. All rate increases are contingent on federal approval. This provision will also provide funding for one additional holiday for workers in the SEIU collective bargaining unit. Lastly, it will fund one-time $1,000 bonuses at six month of employment for workers in the bargaining unit.

CFSS Career Ladder Tiered Rates

Effective January 1, 2025, this provision implements a tiered rate schedule for PCA/CFSS. The tiered rate will begin at the base rate add-on effective January 1, 2025 of 5.10%, a net increase of 21.98% from current rates, and will increase as people gain experience. Experience will be measured by the number of hours billed for services provided by the individual worker. Below are the tiers

Time worked	Target Wage	Rate Increase Effective 1/1/25	Rate Increase Compared to Current Law
Under 6 months (0 - 1,000 hours)	$20.00	5.10%	21.98%
6 months (1,001 – 2,000 hours)	$20.50	7.75%	24.63%
1 year (2,001 – 6,000 hours)	$21.00	10.42%	27.30%
3 years (6,001 – 10,000 hours)	$21.70	14.07%	30.95%
5+ years (10,001+ hours)	$22.50	18.29%	35.17%

Funds to cover costs related to administering the Collective Bargaining Agreement (CBA) with SEIU
This provision provides funding for three ongoing FTEs the state needs to adequately support the work of bargaining and responding to requests from SEIU Healthcare.

This provision also includes $1,400,000 for one-time stipends for Individual Providers covered by the CBA. One-time stipends are for members who provided services to at least one PCA Choice participant during the pay periods between December 1, 2020 and February 7, 2021 and who attest that they received a compensation increase of less than the value of $0.29 (the estimated average cost per hour of 20% of the rate add-on) per hour wage increase (e.g., lump sum, wage adjustment) times the number of hours worked during the time period when a temporary rate increase was in effect. $1.4 million will be dispersed across all PCAs who apply and are eligible for the stipend, prorated based on the number of hours worked during the time period that the temporary rate increase was in effect. An additional 15% is included for the administration of these stipends by a 3rd party vendor.

Lastly, this provision includes $5,600,000 for one-time stipends of $200 to bargaining members to offset the potential costs related to people using individual devices to access Electronic Visit Verification (EVV). An additional 15% is included for the administration of these stipends by a third-party vendor.

Funding for provider training stipends, provider orientation, and Orientation Trust
This provision provides funding for stipends of $500 for collective bargaining unit members who complete designated, voluntary trainings made available through or recommended by the State Provider Cooperation Committee. It also provides funding for an optional orientation for CBA members to participate in voluntary orientation, including a $100 payment for completion of orientation and administrative resources to support orientation requirements. Lastly, this proposal establishes a Taft-Hartley Trust to cover orientation-related expenses.

Allow for two person cares PCA/CFSS cares
This provision allows for a person to choose to use more than one PCA/CFSS worker at the same time. This flexibility will better meet people's individual support needs. Examples of when a person might need more than one worker include when one worker is grocery shopping for a person and another is supporting the person at home or when a person needs a more experienced worker to provide services with a less experienced staff in order to improve the quality of the services being provided.

Home Care Nursing Clarification
This provision clarifies that home care nursing services will be authorized under CFSS in the same manner they were under PCA by adding a cross-reference to CFSS in the statute that outlines the requirements for the manner and amount of home care nursing services.

Impact on Children and Families:

The PCA program is used by people of all ages, including pregnant women, children, and families. In January 2018, 2.1% of PCA recipients were under the age of 5; 17.6% of recipients were between the ages of 5 and 17; and 3.5% were between the ages of 18-22. While DHS does not have a data measure to determine how many family units receive PCA in their home(s) and communities, we know that in addition to children receiving PCA, some parents also receive PCA. This proposal could positively impact children and young adults who receive PCA by improving

the quality, availability, and retention of workers to provide the service. It also stabilizes families who typically experience higher rates of poverty when caring for a child with a disability, by providing support and an ability for many to work.

Equity and Inclusion:

The PCA/CFSS program is one of the most diverse long-term service and support programs in Minnesota and has been growing more diverse over time. In January of 2021, 55% of home care (PCA) participants were people of color or Native American. Approximately 36% of home care (PCA) recipients were non-Hispanic white, compared to an estimated 80% of Minnesotans statewide.

Home care workers, of which PCA workers represent the largest share of workers, themselves are overrepresented by women, people of color and people who have immigrated to the United States. An evaluation of home care workers in 2022 found that 85 percent of home care workers nationally are women, often times single mothers. And while people of color make up roughly 40 percent of the of US workforce, nearly 63% of the home care worker labor force versus 40%. The same data found that immigrants make up roughly 16 percent of the workforce yet constitute nearly 31 percent of the home care workforce. Nationally, home care workers earn a median annual income of $19,100 and 1 in 6 homecare workers live below the federal poverty line. Much of the rate increase resulting from this proposal would be expected to be passed along to the direct care workers and, in turn, reach this diverse pool of low-wage workers.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

While this provision does not have direct impact on Tribal operations, the American Indian people disproportionately comprise PCA participants. In addition, the workforce is likely to include a disproportionate share of American Indians. Increased rates will positively impact American Indian communities and lead to improved wages and benefits.

Impacts to Counties:

This proposal will not impact counties financially.

Results:

The results of this proposal will be:

1. A higher rate for the CFSS program with increases built into the rates to provide higher wages for workers with more experience will result in higher compensation for PCA/CFSS workers and will enable agencies and people with disabilities to attract and retain workers. The effectiveness of higher base wages and the implementation of rate tiers will be measured through dedicated evaluation and research.
2. Increased upward mobility for CFSS workers, which is intended to attract and retain workers at higher rates;
3. An increase in the quality of person-centered plans in Minnesota for people with disabilities.

Summary of proposal components:

#	Proposal Component	Component Detail	FY24	FY25	FY26	FY27
1)	PCA/CDCS Rate Increases	19.00 Wage Floor Effective January 1, 2024	54,679	132,842	138,120	140,132
		20.00 Wage Floor Effective January 1, 2025	0	6,665	17,192	17,418
		PCA Rate Tiers	0	31,747	78,533	79,708

#	Proposal Component	Component Detail	FY24	FY25	FY26	FY27
2)	Other SEIU Rate Adjustments	Removal of 600 Hour Threshold before PTO earned, 1 new paid holiday, interactive effects.	2,843	7,202	7,891	8,003
3)	Electronic Visit Verification Grants	Funding to provide one-time $200 payment to individual providers to cover costs of devices to use for EVV	5,600	0	0	0
		Contractor Costs to administer EVV stipend	495	0	0	0
4)	COVID-19 Stipends	Funding for one-time payments to individual providers up to $1000 related to federal funding for temporary rate enhancements.	1,400	0	0	0
		P/T Contract costs to administer one time payments	200	0	0	0
5)	SEIU Orientation	Orientation-Committee Related Costs, such as trainers, content development, video creation, meeting space, & committee members (up to $5,000 per member per FY)	500	500	0	0
		One-time stipend of $100 for individual providers completing orientation.	1,500	1,500	0	0
		Orientation Trust - Establishment of Taft-Hardley trust fund for future orientation activities.	1,000	0	0	0
		FTE costs for a SEIU Orientation Program Coordinator	192	224	0	0
6)	Rate Tier Implementation	MMIS, MPSE, MNCHOICES, and Data Warehouse systems work to create individual providers tier reports, update provider files and automatic claim add-on.	227	45	45	45
		Provider enrollment staff to oversee tier related provider file issues.	0	83	73	73
		Administrative staff for PCA tier related cost reporting, labor market data collection, research and evaluation, policy development, cross-agency coordination, grievance work, and produce trainings/communications.	446	906	908	908
7)	Retention Bonus	Funding to provide $1000 retention bonus to 50,000 workers at 6 months of service.	50,000	0	0	0
		Contract costs to administer Stipend.	750	0	0	0
8)	Training Admin and stipends	Funding to provider $500 stipends for individual providers who complete designated, voluntary trainings	2,000	0	0	0

#	Proposal Component	Component Detail	FY24	FY25	FY26	FY27
		recommended by the State Provider Cooperation Committee.				
		Contract to administer training stipends.	100	100	0	0
9)	DSP Retirement Benefits Study	Study of direct service provider retirement needs and future benefit options.	102	51	0	0
10)	Other SEIU Administrative Costs	Positions to handle future SEIU negotiations work and grievances.	270	312	312	312
11)	Other CFSS Admin	Fiscal analysis lead position for SEIU negotiation costs and CFSS rate projection analysis.	98	115	115	115
12)	Home Care Nursing/CFSS Caps	Correct language inadvertently removing hour/day cap on CFSS participants also eligible for Home Care Nursing.	(1,451)	(5,340)	(5,828)	(5,952)
	Totals		120,953	176,954	237,361	240,761
		Total Costs	**FY 24-25**	***297,907***	**FY 26-27**	***478,1242***

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
General Fund			120,953	176,954	297,907	237,361	240,761	478,123
HCAF								
Federal TANF								
Other Fund								
Total All Funds			120,953	176,954	297,907	237,361	240,761	478,123
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	33	MA LW (FFS)	43,634	134,650	178,284	183,574	186,212	369,786
GF	33	MA ED (MCO)	11,871	36,715	48,585	49,951	50,678	100,629
GF	34	AC	566	1,752	2,319	2,383	2,418	4,801
GF	11	Systems and HCA MMIS Staff Admin	377	158	535	148	148	296
GF	14	Admin	1,411	2,322	3,733	1,920	1,920	3,841
GF	55	Grants	63,545	2,100	65,645	0	0	0
GF	REV1	Admin FFP @ 32%	-451	-743	-1,194	-615	-615	-1,230
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	14	ADSA Admin	12	16		14	14	

Statutory Change(s):

Minn. Stat. Sec. 256B.851

Change Item Title: Child Care Assistance Program Maximum Rate Update

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	21,655	95,204	126,983	133,014
Revenues	0	0	0	0
Other Funds				
Expenditures	22,000	8,000	8,000	8,000
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	43,655	103,204	134,983	141,014
FTEs	**1**	**1**	**1**	**1**

Recommendation:

The Governor recommends investing $116.8 million from the general fund and $30 million from the Child Care Development Fund (CCDF) in the FY 2024-25 biennium for changes to the Child Care Assistance Program (CCAP) to update the maximum rates paid to child care providers to the 75th percentile of the most recent market survey. In the FY 2026-27 biennium, the Governor recommends $260 million from the general fund and $16 million from the CCDF. Updating the maximum rates supports families, children, and child care providers across the state.

Additionally, this proposal increases the average cost of child care, resulting in an increases in the cost of other child care proposals in the Governor's recommendations. This adds $5.9 million in FY 2025, $14.2 million in FY 2026 and $15.3 million in FY 2027 to the general fund cost.

Rationale/Background:

This proposal impacts most providers and families receiving child care assistance with the intended result to improve access to the child care market and ensure that Minnesota achieves the federally recommended benchmark for equal access by setting rates to the 75th percentile of the most recent market rate survey.

History

The Child Care and Development Block Grant Act of 2014 requires that states ensure CCAP-eligible children have equal access to child care services provided to other children.[1] Federal law also requires that states update their survey of child care market rates every 3 years,[2] and the final federal rule requires that CCAP rates be based on the most recent market rate survey.[3] Further, the federal Administration for Children and Families (ACF) has specified that setting rates at the 25th percentile is the lowest measure of equal access allowed and that states should be prepared to set rates higher in the future to remain in federal compliance.[4] Currently, the federally recommended benchmark to ensure equal access to the full child care market is to set rates at the 75th percentile or higher of the most recent market rate survey.[5]

CCAP pays a child care provider's charge or, if less, a maximum hourly, daily or weekly rate that is calculated based on state law. These rates are referred to as "maximum rates." Every 3 years DHS conducts a statewide

[1] Public Law 113-186, Section 5b(4)(A). https://www.congress.gov/113/plaws/publ186/PLAW-113publ186.pdf.

[2] 42 U.S.C. § 9858c(c)(4)(B). "Requirements of a Plan: Payment Rates, Survey." https://www.law.cornell.edu/uscode/text/42/9858c.

[3] 45 CFR 98.45. "Equal Access." https://www.law.cornell.edu/cfr/text/45/98.45.

[4] Shannon Christian, ACF Office of Child Care, to Chad Dunkley and Clare Sanford, Minnesota Child Care Association, July 3, 2019. Letter.

[5] ACF Office of Child Care. "CCDF Payment Rates – Understanding the 75th Percentile." https://childcareta.acf.hhs.gov/sites/default/files/public/508ed-75th_percentile_exercise.pdf.

survey of prices charged by licensed family child care and licensed center child care providers, referred to as a "market rate survey." The 2021 legislature set current maximum rates to the 40th percentile of the 2021 market rate survey for infants and toddlers and the 30th percentile of the 2021 market rate survey for preschool and school aged children. In January 2025, these rates will update based on results of the 2024 market rate survey. These changes brought Minnesota into compliance with rate requirements through Federal Fiscal Year 2024. The 2025 increase will be reflected in the Federal Fiscal Year 2025 – 2027 Child Care Development Fund (CCDF) Plan and may meet minimum requirements at the 30th and 40th percentiles. Minnesota will be out of compliance if the legislature does not update rates to the 2027 survey.

Impact of low rates on child care providers

When payment rates are too low, providers are less likely to serve families who are eligible for CCAP. Providers who choose to accept the low payment rates often struggle to offer quality care, attract and retain staff, purchase sufficient supplies, and maintain facilities. These providers are often left struggling to keep their doors open.[1] Some do not stay open.

Impact of not updating rates with the most recent market rate survey

Updates to maximum rates support providers who serve families receiving CCAP by ensuring they receive payments comparable to what they would receive from private pay families. Predictable revenues also support providers' ability to run their business when faced with unexpected challenges, such as COVID-19. Allowing maximum rates to increase with each new survey also maintains alignment with the market. Increasing CCAP maximum rates and updating after each market rate survey will help ensure families and children can receive assistance from CCAP to access child care and reduce the need to pay out of pocket. Failing to increase maximum rates and update the maximum rates based on the most recent market rate survey puts access to CCAP reimbursement in jeopardy since many providers do not accept CCAP because the rates are too low.

Prior to the rate update in the 2020 Legislative Session, CCAP maximum rates were based on data collected in 2011. This led to CCAP rates fully covering 16% of licensed family child care providers and 23% of licensed child care center prices at the time of the update in 2020.

Proposal:

This proposal updates CCAP maximum rates every 3 years after each market rate survey. Maximum rates would be set at the 75th percentile of the most recent rate survey or the rates in effect at the time of the update, whichever is greater. Many rates would increase, some rates would stay the same, and no rates would decrease.

The first update would be made in October 2023 using the 2021 rate survey. The second update would be in January 2025 using the 2024 rate survey. Maximum rates would then be updated every third January following the market rate survey. The proposal adds one additional FTE licensor position to meet the needs of child care programs that seek licensure or need to renew a license.

This proposal increases the cost of other proposals included in the Governor's recommendations that expand access to MFIP child care and the Basic Sliding Fee. Specifically, the combined general fund cost of Supporting Child Care for Foster Parents and Relative Caregivers, Permanent Reprioritization of the CCAP BSF and Supporting Working Minnesotans will grow by $6.4 million in FY2025, $14.7 million in FY2026 and $15.6 million in FY2027.

Impact on Children and Families:

CCAP helps families pay for child care so that parents can work or go to school. It helps ensure that families can access affordable child care and children are supported to achieve their highest potential in child care settings that best meet family needs and preferences. CCAP typically serves approximately 15,000 families and 30,000 children each month. An average of 2,650 providers receive CCAP payments each month. Counties and tribal agencies administer CCAP. As of FY 2021, only 27% of Family Child Care providers and 68% of Licensed Centers

[1] National Women's Law Center. At the crossroads: State child care assistance policies 2021. https://nwlc.org/wp-content/uploads/2022/06/State-of-Child-Care-2022-WIP-accessibility.pdf

were registered to serve families receiving CCAP. This proposal will make CCAP rates more competitive in an already tight child care market, potentially increasing the number and percent of all types of providers willing to take CCAP payments.

This proposal will increase access to affordable child care, a critical component in preventing family and child entry into the child protection system.

Equity and Inclusion:

Updating CCAP maximum rates based on the most recent market rate survey will increase access to affordable, quality child care for families receiving CCAP. This proposal will benefit families of color, particularly African American families, and prove beneficial as parents and legal guardians pursue employment or educational opportunities. Tribally licensed providers serving children receiving CCAP will also see a rate increase.

In State Fiscal Year 2021, 68% of all children served by CCAP were children of color, specifically African-American, Asian/Pacific Islander, Hispanic/Latino, multiple races, and American Indian children. Of all children served, 54% are African-American. Accordingly, any rate increase for children and families receiving CCAP, and/or the providers who serve them, is likely to benefit African-American children.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

This proposal will impact White Earth Nation and Red Lake Nation specifically as they administer CCAP in partnership with the state. Other Tribal Nations may have participants receiving CCAP, but those cases are administered through a county or other local agency. This proposal does not create any new responsibilities or duties for tribal administrators. Tribal administrators may see small increased caseloads due to more families utilizing CCAP. Tribal Nations have voiced support for this proposal.

Impacts to Counties:

Most counties have expressed support for increasing CCAP maximum payment rates. This proposal would not add any new responsibilities or duties for counties. Counties may see small increased caseloads due to more families utilizing CCAP. Counties support language that directs Basic Sliding Fee allocations increase proportionately to the rate increases tied to market rate changes.

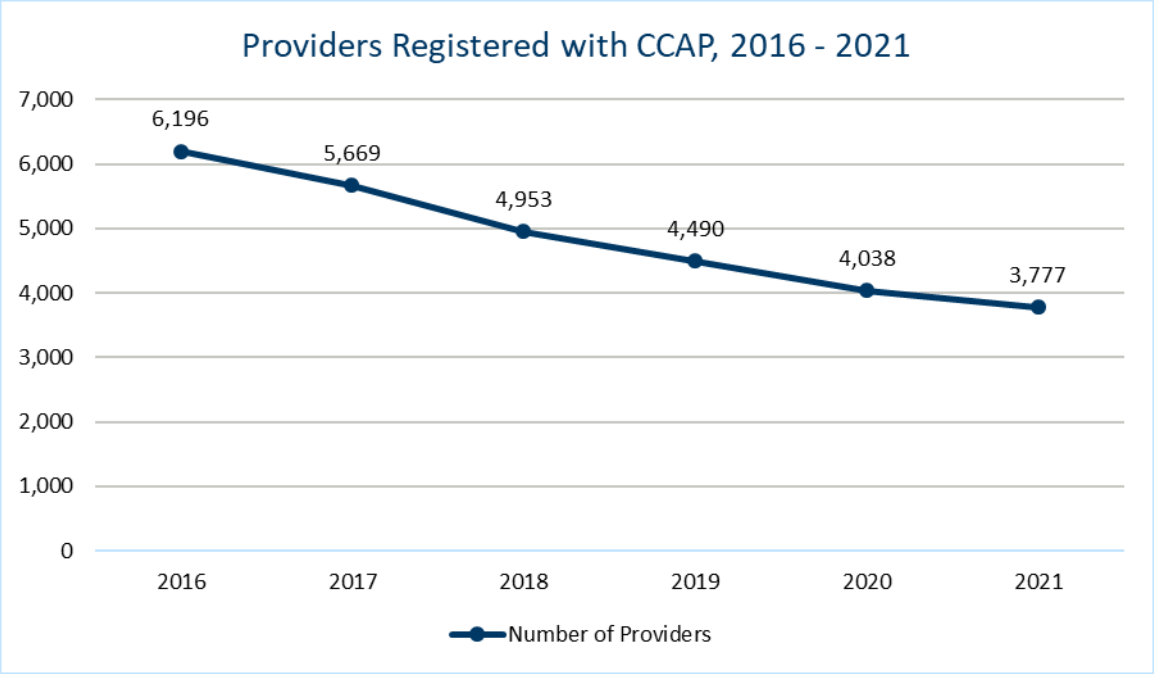
IT Costs:

The Minnesota Electronic Child Care Systems, or MEC^2, the automated system that supports CCAP, will need changes in order to implement this proposal. MN.IT estimates the cost of updating a new rate will be $37,026 each time rates are updated. Due to related changes paid for by the 2021 Legislature, the net cost in FY24 is $33,438 (because this will be paid with federal CCDF dollars, whole dollars are tracked for FY24, rather than state share only). The related change paid for by the 2021 Legislature results in a net cost of $33,438 (state share of $18,391) in FY25 and $37,026 (state share of $20,364) in FY28. MN.IT estimates the ongoing maintenance cost at $7,405 (state share of $4,073) in FY26, FY27 and FY29 when a rate change does not occur.

Results:

This proposal impacts most providers and families receiving CCAP with the intended result to improve access to the child care market, which is a critical component in preventing family and child entry into the child protection system. Increasing CCAP maximum rates and updating after each market rate survey will help ensure families and children continue to receive assistance from CCAP to access child care and reduce the need to pay out of pocket. Failing to increase maximum rates and update the maximum rates based on the most recent market rate survey puts access to CCAP reimbursement at risk should providers decide not to accept CCAP because the rates are too low. Under this proposal the number of providers registered with CCAP is expected to increase. This proposal

aligns Minnesota with the federally-recommended benchmark for equal access by setting rates at the 75th percentile of the most recent market rate survey.



NOTE: The years shown are calendar year.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			21,655	95,204	116,859	126,983	133,014	259,997
HCAF								
Federal TANF					-			-
Child Care Development Fund			22,000	8,000	30,000	8,000	8,000	16,000
Total All Funds			43,655	103,204	146,859	134,983	141,014	275,999
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
General Fund	22	MFIP Child Care	20,710	55,302	76,012	73,980	82,347	156,327
CCDF	42	Basic Sliding Fee	22,000	8,000	30,000	8,000	8,000	16,000
General Fund	42	Basic Sliding Fee	837	33,412	34,249	38,171	34,952	73,124
General Fund	11	Operations Admin	133	153	286	153	153	306
General Fund	11	MEC2 (state share @ 55%)	18	18	36	4	4	8
General Fund	REV1	Admin FFP @32%	-43	-49	-92	-49	-49	-98
General Fund	22	MFIP Child Care (Interaction)		2,648	2,648	4,394	5,108	9,503
General Fund	42	Basic Sliding Fee (Interaction)		3,720	3,720	10,330	10,499	20,829
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
General Fund	11	Licensing (1 FTE)	1	1		1	1	

Statutory Change(s):

Minn. Stat. § 119B.13, subd. 1

Change Item Title: Expanding MA Coverage for Children

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	2,257	19,042	42,768	52,776
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	2,257	19,042	42,768	52,776
FTEs	**0**	**4**	**4**	**4**

Recommendation:

The Governor recommends implementing up to 72 months of continuous eligibility for children under age 6, and 12-month continuous eligibility for children ages 6 through age 20. These changes will simplify eligibility and enrollment in Medical Assistance, reduce disruptions in health care coverage for children, and lessen the administrative burden that occurs due to churn. Under the recently enacted Consolidated Appropriations Act, P.L. 117-328, section 5112, all Medicaid programs are required to adopt 12-month continuous eligibility for children under age 19 by January 1, 2024. This proposal would require an investment of $21,299,000 in FY2024-2025 and $95,545,000 in FY2026-2027.

Rationale/Background:

Continuous eligibility for children is a long-standing retention strategy for states, and 32 states already offer 12-month continuous eligibility for children. Recognizing the importance of the first five years on early brain development and what has occurred in the past two years during the COVID-19 pandemic, this proposal would grant additional months of continuous eligibility for children under age 6, for a period of up to 72 months. Once a child under age six is determined eligible for Medical Assistance, they would continue to be eligible through the month of their sixth birthday.

In addition, under this proposal, a child age six through age 20, regardless of the child's basis of eligibility, would remain eligible for Medical Assistance for a period of up to 12 months, until their annual renewal, unless the child turns age 21, ceases to be a Minnesota resident, voluntary requests closure, or dies. If the child is still eligible for Medical Assistance at their annual renewal, they would receive another 12 months of eligibility. If they are no longer eligible for Medical Assistance at renewal, they could then be moved to another Minnesota Health Care Program.

DHS will initially seek federal approval via a state plan amendment to extend 12 months continuous eligibility to all children under age 19. To extend continuous eligibility for an additional 60 months for children under age six, and provide 12-month continuous eligibility for children ages 19 and 20, DHS will pursue an 1115 Medicaid Demonstration Waiver.

Continuous eligibility will vastly simplify the eligibility and enrollment process for all children enrolled in MA and will protect children from churning off and back on the program when temporary changes, such as fluctuations in family size or household income occur, and for children under age six, when late paperwork or other administrative barriers would otherwise cause coverage to end.

Proposal:

This proposal would authorize two important eligibility expansions for children:

- Up to 72 months of continuous Medical Assistance eligibility for children under the age of six. Once a child under age six is determined eligible for Medical Assistance, the child would remain eligible for MA, with limited exceptions, through the month of the child's sixth birthday.
- Twelve months of continuous Medical Assistance (MA) eligibility for children age six through age 20. Once a child is determined eligible for MA, they would maintain that eligibility for a 12-month period, until their annual renewal, regardless of most changes in circumstances that would typically result in closure. 12-month continuous eligibility would apply to a child through the month of the child's 21st birthday.

DHS requests 4 FTEs to carry out this proposal:

- 1 FTE will serve as the eligibility policy expert resource, conduct research, and develop, implement, support and maintain the eligibility policies for this change. This FTE will conduct ongoing community engagement, seeking input and feedback from stakeholders during and following implementation, particularly those from and focused on underserved communities. This FTE will review and approve worker and enrollee facing materials, respond to inquiries, present to internal and external groups and provide interpretations for trainers, systems staff and others. This FTE will assist Federal Relations with pursuing the necessary federal approvals to implement.
- 1 FTE will develop, implement and maintain eligibility worker and assister training, draft, implement and maintain procedures and systems instructions, draft eligibility notices, and perform other project work.
- 1 FTE will serve as the operational business lead on the IT project to ensure MHCP deliverables including business requirements, design documents, communication plans, test plans, and workflows. This FTE will serve as the ongoing technical and operational expert for maintenance and daily operations.
- 1 FTE will conduct necessary analysis and financial reporting necessary for the two 1115 waivers outlined above.

FTEs are assumed to start at the beginning of FY25.

This proposal would require changes in policy and IT systems, an 1115 waiver from CMS, a State Plan amendment, and an FTE investment. In addition, DHS would require a contract amendment to provide Child & Teen Check-ups, Vaccine outreach, and Prior Authorization to the newly covered population, which would cost $1 million per fiscal year in total dollars upon full implementation.

The effective date of this proposal is assumed to be January 1, 2025.

Impact on Children and Families:

While the obvious benefit of continuous eligibility is that it limits the churn of children on and off Medicaid, the health benefits are far greater. A study from the Government Accountability Office (GAO) discovered that Medicaid enrollees who had coverage for a full year reported fewer difficulties in accessing services and obtaining necessary care, compared to those who only had partial year insurance and were more likely to report problems with obtaining care.[1] Guaranteeing ongoing coverage ensures that children can receive appropriate preventative and primary care, as well as treatment for any health issues that arise. Stable coverage also enables providers to develop relationships with children and their families.

Equity and Inclusion:

This proposal is in keeping with the analyses and calls to action described in DHS' February 2022 report, "Building Racial Equity into the Walls of Minnesota Medicaid."

[1] Georgetown University Health Policy Institute, Center for Children and Families, Continuous Coverage in Medicaid in CHIP, July 2021, pg. 6.

An analysis of 2018 American Community Survey (ACS) data by the State Health Access Data Assistance Center (SHADAC) shows that, in Minnesota, 64% of Black children, 54% of American Indian/Alaskan Native children, and 52% of Hispanic/Latino children receive their health care coverage through Medical Assistance, as compared to 17% of white children. Families with low and moderate household incomes are likely to experience 2-3 months of year in which their income is higher than the Medicaid threshold, due to seasonal employment, variable work hours, or occasional overtime pay.[2]In addition to improving health care access, continuous eligibility promotes health equity. Black, Hispanic, and Indigenous individuals are more likely to live in poverty and have higher rates of income volatility.[3] Families with volatile incomes are also more likely to experience other adverse situations, such as food insecurity, unstable housing, greater parental stress, and reduced child academic attainment.[4] Losing coverage, even temporarily, compounds the other challenges these families encounter.[5] Access to health care can help mitigate these negative effects, while also ensuring that medical debt, the most common cause of bankruptcy, does not increase these difficulties.[6]

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Counties and tribal agencies will be responsible for following and effectuating the policy change through their role as processing entities. DHS will engage with county and tribal workers to develop procedures and will communicate these changes with the counties. Continuous eligibility is not a new policy concept, as it is already in place for pregnant women on MA and children born to women enrolled on MA (known as the auto newborn basis of eligibility). Implementing continuous eligibility for children under age 21 will reduce worker administrative tasks for workers that occur when children move back and forth between programs or lose eligibility between renewals, just to re-enroll months later. Workers will still need to process changes reported between renewals, but most will not result in changes in eligibility for enrolled children. For families with both children and parents enrolled, continuous eligibility for children will make it easier for parents to regain coverage, because the family case will remain open even if the parent loses eligibility temporarily during the year.

Impacts to Counties:
Counties and tribal agencies will be responsible for following and effectuating the policy change through their role as processing entities. DHS will engage with county and tribal workers to develop procedures and will communicate these changes with the counties. Continuous eligibility is not a new policy concept, as it is already in place for pregnant women on MA and children born to women enrolled on MA (known as the auto newborn basis of eligibility). Implementing continuous eligibility for children under age 21 will reduce worker administrative tasks for workers that occur when children move back and forth between programs or lose eligibility between renewals, just to re-enroll months later. Workers will still need to process changes reported between renewals, but most will not result in changes in eligibility for enrolled children. For families with both children and parents enrolled, continuous eligibility for children will make it easier for parents to regain coverage, because the family case will remain open even if the parent loses eligibility temporarily during the year.

IT Costs
Because this proposal applies to all children under age 21, regardless of basis of eligibility, changes would be required in METS, MAXIS, and MMIS. Continuous eligibility currently exists for people eligible for Medical Assistance under the Pregnant Women and Auto-Newborn bases of eligibility, but expansion of continuous

[2] Georgetown University Health Policy Institute, Center for Children and Families, Continuous Coverage in Medicaid in CHIP, July 2021, pg. 6
[3] *Id.*
[4] *Id.* at pg. 7.
[5] *Id.* at pg. 6.
[6] *Id.* at pg. 7.

eligibility to children under age 21 would require changes to eligibility determination logic, notices, renewals, and federal reporting requirements.

IT changes will require a total dollar up-front investment of $5,741,639, with ongoing costs of $1,148,328. DHS assumes state share at 38% for METS, 55% for MAXIS, and 29% for MMIS.

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of children under age 21 who retained eligibility due to continuous eligibility when they would have normally lost MA eligibility Number of children under age 6 who retained eligibility due to continuous eligibility when they would have normally lost MA eligibility	N/A. Continuous eligibility does not currently exist in MN.	Sept. 2022	N/A. Continuous eligibility does not currently exist in MN.	Unknown	July 2025 (this can be measured one year following the effective date)
Quality	Continuous eligibility for children will improve the state's overall ability to measure Quality of Health Care, as continuous enrollment with no more than a one-month gap in coverage is often a pre-requisite for most health care quality measures (such as preventative care, immunization rates, and medication management).	N/A. Continuous eligibility does not currently exist in MN.		N/A. Continuous eligibility does not currently exist in MN.	Unknown	July 2025 (this can be measured one year following the effective date)

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Results	Frequency with which children under age 21 access health care during their continuous coverage period Frequency with which children under age 6 access health care during their continuous coverage period	N/A. Continuous eligibility does not currently exist in MN.		N/A. Continuous eligibility does not currently exist in MN.	Unknown	July 2025 (this can be measured one year following the effective date)

To assess the quantity measures, DHS will compare data on churn from before the effective date of the change to the amount of churn 1 year following the effective date.

Individuals with gaps in coverage are excluded from the data used to assess the quality of care, thus providing an inadequate picture of how well MA is performing on key quality indicators. Beginning in 2024, states will be required to report on the Child Core Set of Health Care Quality Measures in Medicaid and CHIP. Without continuous enrollment, assessing the quality of care in Medicaid will be incomplete and may misrepresent how well Medicaid and CHIP are performing.[7]

Evidence-based Practice	**Source of Evidence**
Health insurance access	Continuous Eligibility for Medicaid (Source: Brantley (2022), https://journals.sagepub.com/doi/pdf/10.1177/10775587211021172)

[7] Georgetown University Health Policy Institute, Center for Children and Families, Continuous Coverage in Medicaid in CHIP, July 2021, pg. 7.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			2,257	19,042	21,299	42,768	52,776	95,544
HCAF								
Federal TANF								
Other Fund								
Total All Funds			2,257	19,042	21,299	42,768	52,776	95,544
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	33ED	MA Grants	0	813	813	1,751	1,924	3,675
GF	33FC	MA Grants	0	17,423	17,423	39,495	49,330	88,825
GF	13	HCA Admin - Contract	0	500	500	1,000	1,000	2,000
GF	13	HCA Admin - FTEs (0, 3, 3, 3)	0	514	514	461	461	922
GF	11	OPS Admin - FTEs (0, 1, 1, 1)	0	171	171	153	153	306
GF	REV1	FFP @ 32%	0	(379)	(379)	(516)	(516)	(1,032)
GF	11	State Share of Systems Costs	2,257	0	2,257	424	424	848
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	13	HCA Admin - FTEs (0, 3, 3, 3)	0	3		3	3	
GF	11	OPS Admin - FTEs (0, 1, 1, 1)	0	1		1	1	

Statutory Change(s):

Minnesota Statutes, section 256B.056, subd. 7

Change Item Title: Older Adult Long Term Care Workforce

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	5,989	34,601	45,328	54,194
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	5,989	34,601	45,328	54,194
FTEs	**3**	**5**	**5**	**5**

Recommendation:

The Governor recommends investing $40.59 million in fiscal years 2024-2025 and $99.52 million in fiscal years 2026-2027 from the general fund to address Minnesota's workforce crisis within aging services through an increase to home and community-based service rates delivered under the Elderly Waiver (EW), Alternative Care (AC), and Essential Community Supports (ECS) programs. This will be accomplished by further phasing-in the rate-setting methods as recommended by a 2019 DHS legislative report in order to account for providers' costs to deliver these services, driven in large part by the cost of paying workers.

The Governor also recommends addressing the workforce crisis by leveraging people's informal support networks, through an increase to monthly budgets for people using the Consumer-Directed Community Supports (CDCS) option under EW and AC.

This proposal increases rates an average of 8.91% effective January 1, 2024 and applies to inflationary adjustments that increase rates on average by 10.06% effective January 1, 2026, relative to forecasted spending on Elderly Waiver services.

Rationale/Background:

The Elderly Waiver (EW), Alternative Care (AC) and Essential Community Supports (ECS) programs fund home and community-based services (HCBS) for people 65 years old and older on Medical Assistance (MA), and who require the level of care provided in a nursing home but choose to live in the community. These programs provide services and supports for people to live in their homes or a community setting and may delay or prevent nursing facility care. The purpose of these programs is to promote community living and independence with services and supports designed to address each person's individual needs and choices.

Minnesota is currently experiencing an unprecedented workforce shortage in the long term care sector. While job vacancies in Minnesota are at record highs across all sectors, healthcare and social assistance sectors have the most severe workforce shortages, with more than 52,000 vacancies in the fourth quarter of 2021. These vacancies increased by 66 percent in just one year. While many industries are able to adjust their business models and financial structures to accommodate changing economic and demographic conditions, providers of Medicaid services in the long-term care sector are unable to change prices to accommodate the wage increases needed to compete with other industries.

The Elderly Waiver, Alternative Care, and Essential Community Supports programs have particularly low direct care staff wages due to low reimbursement rates spanning many years. The 2017 Minnesota Legislature enacted

new rate-setting methods in 256S for a wide array of home and community-based services provided for older adults under EW, AC, and the ECS programs. However, when the reforms took effect on January 1, 2019, they were only partially phased-in (based on 10% of the new rate methods in statute, and 90% of the rates in effect as of June 30, 2017).

A 2019 evaluation of EW rate methods found that existing rates for many service rates were not adequate to cover providers' costs and that fully phasing in the methods would yield appropriate rates. Appropriate rates are necessary for providers to be able to pay wages and benefits to direct support workers that are sufficient to attract and retain workers and therefore deliver critical HCBS services.

The elderly waiver rate methods study also resulted in several other recommendations, including:

- Adjustments to the methodologies to more accurately reflect provider costs
- Adjustment to the annual effective date for home-delivered meals changes to align with changes for other services
- Inflationary adjustments every other year
- 100% implementation of the new rate methodologies
- Ongoing evaluation of rate methods and rate values to gather updated information regarding provider costs

The 2021 Minnesota Legislature made an additional investment in these reforms by further phasing in the rate methods. Currently, the rates are based on 18.8% of the rate methods in statute, and 81.2% of the rates in effect as of June 30, 2017. Despite previous investments, current rates for EW, AC, and ECS programs are not sufficient to cover providers' costs for delivering services. This adds to HCBS providers' challenges in attracting and retaining workers to deliver HCBS services, which exacerbates access issues for program participants.

CDCS Budget Parity

The Consumer-Directed Community Supports (CDCS) option under EW and AC is a critical model to help address the workforce shortage. Through CDCS, participants can use their monthly budgets to hire their own workers such as family, friends, and neighbors to provide support. This augments the direct support workforce, promotes participants' choice, and greatly enhances the role of informal caregivers. This may allow a family caregiver to forego other employment and provide more support to the older adult. Participants may also appreciate receiving support from a person of their choice, who they know and trust.

The caregiving experience may also be more stable and enduring, because of the personal relationship between the older adult and caregiver. CDCS also focuses consumer attention on in-home service options instead of residential services like customized living, because residential services cannot be purchased through the CDCS option. By increasing CDCS budgets, we can help address long-term care workforce shortages, enhance consumer choice, and incentivize the use of in-home versus more expensive residential services.

Proposal:

Current rates for EW, AC, and ECS programs are not sufficient to cover providers' costs for delivering services. In addition, the rate-setting methods in 256S need to be much more fully phased-in to help ensure that people have access to critical home and community-based services (HCBS) across the state. This adds to HCBS providers' challenges in attracting and retaining workers to deliver HCBS services, which exacerbates access issues for program participants.

This proposal has two components to address the workforce crisis within aging services:

1. **HCBS rate increases.** This proposal implements changes to the rate-setting methods in 256S, including any adjustments, as outlined in the recommendations section of the 2019 evaluation of EW rate methods report. The proposal also increases the phase-in of the rate-setting methods in 256S for a wide array of home and community-based services provided under Elderly Waiver (EW), Alternative Care (AC), and

Essential Community Supports (ECS). The proposal adds a requirement that providers direct 80% of any increased revenue resulting from rate increases toward compensation-related costs for employees. It implements a new cost reporting requirement for EW, AC, and ECS providers. Finally, the proposal would provide every-other year evaluation activities to ensure that the rate-setting methods in 256S continue to reflect providers' reasonable and customary costs to deliver HCBS services.

Implementing these changes will lead to higher, more adequate rates for many home and community-based services, which will in turn support front-line workers who deliver the services. These increases will also help ensure service access and quality for approximately 40,000 older Minnesotans who are supported by EW, AC, and ECS.

The following table shows the projected impact of this proposal on wages for major service types based on findings from the 2021 DHS Labor Market Survey of direct support professionals conducted in the summer of 2021.

Service / Service Category	Actual		Proposed	
	2022 Rate	2022 Wage	2024 Wage	2026 Wage
Day Services (Adult Day)	14.12	13.81	14.84	15.05
Residential Services (Customized Living-Home Management)	18.72	15.40	17.69	17.85
Unit-based Services (Homemaker)	20.16	14.58	16.44	16.62

This proposal also includes administrative resources to support ongoing evaluation of the rate methods and rate values, and to support a new cost reporting requirement for EW, AC, and ECS providers. The new cost reporting activities will leverage and significantly expand upon existing HCBS provider cost reporting activities occurring within Aging and Disability Services Administration. This will allow DHS to monitor rate sufficiency and to propose any necessary changes to the rate methods. This work will be supported by 5 FTEs and ongoing contract resources.

2. **Consumer-Directed Community Supports budget increases.** This proposal increase Elderly Waiver (EW) and Alternative Care (AC) Consumer Directed Community Supports (CDCS) monthly budgets to be equal to budgets available under traditional EW or AC.

   By increasing CDCS budgets so that they are equal to traditional budgets under EW or AC, we can make CDCS a more attractive option for EW and AC participants. Through increased use of CDCS and through the higher CDCS budgets, we can help address long-term care workforce shortages, enhance consumer choice, and incent the use of in-home versus more expensive residential services. In State Fiscal Year 2021, nearly 1,200 older Minnesotans received support through EW and AC CDCS.

   The table below shows the differences between EW CDCS budgets and traditional EW budgets as of July 1, 2022. The differences between AC CDCS budgets and traditional AC budgets are similar. This proposal would make AC and EW CDCS budget amounts equal to the traditional budget amounts for each program effective January 1, 2024.

Case Mix	EW CDCS Budgets Effective 7/1/2022	Traditional EW Budgets Effective 7/1/2022	% Difference Between Budgets
A	$1,304	$3,824	193%
B	$1,953	$4,352	123%
C	$2,321	$5,106	120%
D	$2,523	$5,271	109%
E	$3,259	$5,814	78%
F	$3,348	$5,992	79%
G	$3,372	$6,182	83%
H	$4,417	$6,975	58%
I	$5,182	$7,159	38%
J	$5,310	$7,633	44%
K	$5,468	$8,891	63%
L	$1,304	$2,946	126%
V	$23,057	$32,354	40%

Impact on Children and Families:

From a whole family, inter-generational perspective, Minnesota children and youth will experience indirect positive benefits from the proposed investments in home and community-based services for older Minnesotans. Many frontline home and community-based services workers are parents to children and youth. By increasing wages for these workers, more resources will be available to support the workers' children. Also, many family caregivers are middle-aged Minnesotans, and many middle-aged Minnesotans are parents to children and youth. By strengthening supports for older Minnesotans, middle-aged family caregivers will have more capacity to support Minnesota children and youth.

Equity and Inclusion:

HCBS rate increases will benefit BIPOC communities because a growing number of EW and AC participants are people are from BIPOC communities. Between 2016 and 2020, the number of BIPOC participants on EW and AC grew from 26 to 32 percent.

Higher CDCS budgets will help us serve people with higher and more complex needs, including individuals with serious mental illness, behavior support needs, and cognitive impairment. CDCS also allows people to hire their own direct support workers, which allows BIPOC participants to choose the workers that best meet their needs, including their friends, family members, or neighbors.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

This proposal does not have a substantial direct effect on one or more Minnesota Tribal governments, however tribal members may benefit from increased access to HCBS services for older adults. At the 2023 Tribal Summit, tribes indicated that they are experiencing challenges due to inadequate rates and HCBS staffing shortages.

Impacts to Counties:

This proposal does not have an impact on county finances or operations. DHS has discussed this proposal with counties, and they have expressed support. As lead agencies, they have experienced challenges accessing HCBS services for program participants due to inadequate rates and HCBS staffing shortages.

Results:

1. **Percent of people who receive services at home** (rather than in a residential services setting) Between State Fiscal Year 2016 and 2020, the percent of people who received services at home on EW and AC increased from 62.1 to 63.3 percent. By increasing EW and AC rates, this positive trend should continue and improve.
2. **Percent of people who choose CDCS** (rather than the traditional EW and AC programs)

Between State Fiscal Year 2017 and 2021, the percent of people who chose CDCS under EW and AC increased from 1.8 to 3.3 percent. By increasing CDCS budgets, this positive trend should continue and improve.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			5,989	34,601	40,590	45,328	54,194	99,522
HCAF								
Federal TANF								
Other Fund								
Total All Funds			5,989	34,601	40,590	45,328	54,194	99,522
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	33	EW Framework Managed Care	3,835	23,119	26,954	29,953	35,596	65,549
GF	33	EW Framework FFS	406	2,552	2,958	3,316	3,946	7,262
GF	34	AC/ECS Rate Increase	262	737	999	859	930	1,789
GF	33	EW CDCS Parity Managed Care	481	4,829	5,310	6,467	7,052	13,519
GF	33	EW CDCS Parity FFS	53	537	590	719	783	1,502
GF	34	AC CDCS Parity	205	2,044	2,249	2,766	2,865	5,631
GF	33	Disability Waiver Customized Living FFS	18	175	193	460	2,386	2,846
GF	11	Systems	390	48	438	198	48	246
GF	14	Rates Oversight FTE MAPE 14L	398	724	1,122	768	765	1,533
GF	14	Rates Evaluation admin (contract)	100	100	200	100	100	200
GF	34	Admin FFP @ 32%	-159	-264	-423	-278	-277	-555
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	14	ADSA Admin (3,5,5,5)	3	5	0	5	5	

Statutory Changes:

MS 256S

Change Item Title: Addressing Deep Poverty for Minnesotans with Disabilities and Disabling Conditions

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	185	21,474	29,983	31,100
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	185	21,474	29,983	31,100
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends changes that improve access to and reduce service gaps in the state's cash assistance programs, and ensure that these programs better meet the needs of recipients. This proposal includes: (1) increasing the General Assistance benefit amount and adding an annual cost of living adjustment; (2) extending the timeframe for people on General Assistance and Housing Support to apply for Social Security Disability benefits; and (3) reforming drug-testing policies for cash assistance programs.

The total general fund investment is $21.659 million in FY 24-25 and $61.083 million in FY 26-27.

Rationale/Background:

Being in deep poverty means that someone's income is half of the federal poverty level or less (< 50% FPL). The U.S. government recognizes a single adult without children, poverty is having income of $1,133 per month; deep poverty is below $566 per month.

Deep poverty results when people are unable to work or when the work available to them is inadequate to move them out of poverty. For many people in deep poverty both of those fundamental challenges coexist in their lives. People are unable to work when they have serious health problems or disabilities; when someone in their household has those conditions and needs significant care; when jobs are unavailable; or when key resources to make work possible, such as transportation, are unavailable. Working can fail to move people out of poverty when jobs do not offer consistent hours; wages are too low; benefits available to higher paid workers are unavailable for lower paid workers; and jobs are not permanent. Some people are in deep poverty for long periods of time. Others move between deep poverty, poverty, and low-income status as circumstances in their lives continually change.

Researchers from the Minnesota Department of Human Services found that the 4.2% of Minnesotan adults covered by Medical Assistance and living in deep poverty have higher rates of chronic health conditions than other adults who also receive Medical Assistance. In their 2020 report, researchers recommended that the state make intentional changes to its public assistance programs in order to make them more accessible for recipients living in deep poverty. This proposal builds on insights from the 2020 report and recommends changes that will improve access and reduce service gaps to the state's cash assistance programs, which serve some of the poorest Minnesotans. The improvements from this proposal will ensure that Minnesota's programs are better meeting the needs of recipients.

Proposal:

This proposal includes the following provisions:

1. Increasing the benefit amount for the General Assistance program.

General Assistance (GA) is a state program created in 1973 for adults without children with the intent of providing assistance to promote public health and welfare. To be eligible, people must meet all the following requirements:

- One of 14 categories related to illness, disability, or injury that prevents them from working enough to meet their basic needs;
- Countable assets of less than $10,000; and
- Countable income less than the maximum grant amount, which is $203 in most households.

The General Assistance monthly benefit amount of $203 has remained the same since 1986. If the state had increased that amount to account for inflation since 1986, the benefit amount today would be over $500 per month. The deep poverty level benefits make it nearly impossible for the state to achieve the expressed goal of this program to support eligible men and women "to maintain a subsistence reasonably compatible with decency and health."

This proposal seeks to remedy this gap by aligning the monthly General Assistance community assistance rate with the Minnesota Family Investment Program (MFIP) one-person transitional assistance standard as authorized in 256J.24, subd. 5 and its annual cost of living adjustment as authorized in 256J.24, subd. 5 (c). This will establish consistency across the cash assistance programs in support of ongoing multi-year work to create more uniform policies across public assistance programs in order to reduce administrative complexity.

The general fund impact of the general assistance portion of this provision is $0 million in FY 2024, $21.474 million in FY 25, $29.983 million in FY 26 and $31.100 million in FY 27. The increase is anticipated to start on October 1, 2024. In addition to the change in the general assistance portion of this change, there would also be systems costs for MAXIS changes for the alignment of the General Assistance (GA) community living benefit standard with the MFIP program and annual COLA increases. The initial total development costs would be $140,989 in FY 2024 with a state share cost of about $77,544. There are ongoing systems costs into the future.

2. Set a 90-day window for people with disabilities who receive General Assistance and/or Housing Support to apply for Social Security disability benefits and meet with a Social Security Administration worker.

Current state law (Minn. Stat. 256D.06 Subd. 5, paragraph (a)) requires any person applying for General Assistance and Housing Support who appears eligible for any other source of benefits (e.g., federal Supplemental Security Income or SSI) to apply for those other benefits within 30 days of applying for General Assistance and/or Housing Support.

The 30-day requirement to apply for SSI is impossible to meet for most applicants in Minnesota, as they must have an interview with the Social Security Administration. The waitlist to obtain an interview with a Social Security Administration worker prevents people from meeting the current 30-day window. According to recent data from Minnesota Social Security Administration field offices, 23 percent of people seeking Social Security based on blindness or disability waited 41 to 61 days between first contact with the office and their appointment. In six of the 17 federal Social Security Administration field offices in Minnesota, a significant majority of cases (97 percent in one of the field offices) were not processed in under 30 days.

Allowing for up to 90 days to apply for Social Security disability benefits acknowledges the average time needed to get a Social Security application submitted, to schedule and get an interview with an applicant's local Social Security field office, and for an applicant to collect all the necessary paperwork to apply for Social Security disability benefits. Additionally, this timeline considers that an applicant may also need to seek help from an agency that provides advocacy and support services for federal disability application benefits under contract with DHS under Minnesota Statute 256D.06 Subd. 5 (c).

Changes are required to the MAXIS system to modify the Housing Support person cooperation test to reflect this change in policy. No changes are required in MAXIS for the General Assistance program as this program is not automated. These systems changes are estimated to require 251 hours of work initially, take approximately 2 months to complete, and an initial total development cost of $24,849 with a state share cost of about $13,667 in FY 2024.

3. Aligning drug-testing policies

Current policy requires people with drug felony convictions who have completed their sentences to submit to random drug testing as a condition of receiving public assistance. Drug testing, however, is not used to help connect people to treatment services. It can result in cutting off people in deep poverty from public assistance.

In the Supplemental Nutrition Assistance Program, Minnesota Family Investment Program, and Diversionary Work Program policy, a first failed drug test results in a reduction to someone's benefits and a second failed drug test results in permanent disqualification. In General Assistance and Minnesota Supplemental Aid policy, two different five-year disqualification periods for people with a drug felony conviction apply:

- Anyone with a drug felony conviction is disqualified for five years unless they regain eligibility by attending and/or completing a drug treat treatment program, after which they are subject to random drug testing as a condition of continued eligibility.
- Participants with a drug felony conviction are also subject to a five-year disqualification for failing a drug test or following another drug conviction.

The current policy reinforces unfounded stereotypes of public assistance participants and makes the experience of receiving assistance one of surveillance rather than help. According to 2019 data, very few people receiving assistance test positive for drug use: 49 people in the Supplemental Nutrition Assistance Program failed drug tests; 10 people in the Minnesota Family Investment Program failed drug tests; 7 people in General Assistance failed drug tests; and 2 people in Minnesota Supplemental Aid failed drug tests.

This proposal would make it optional for counties and tribes to conduct random drug testing of people convicted of drug offenses. It would remove all sanctions and disqualifications for people with felony drug convictions. Instead, if the county or tribe chooses to require random drug testing and a person test positive for an illegal controlled substance, the local agency must provide a referral to a drug treatment program.

This initiative increases costs to the Minnesota Family Investment Program, and Diversionary Work Program, the General assistance program and the Minnesota Supplemental Aid program at $94,026 in FY 2024, $100,933 in FY 2025, $102,170 in FY 2026 and $103,256 in FY 2027.

Impact on Children and Families:

The General Assistance program is primarily for adults without dependent children. While people on GA do not have dependent children, they are indeed someone's child and they deserve to live in dignity with their basic needs met. Often, people on GA have children and grandchildren that are not dependent, but may be in their care for periods of time. They may still pay for gifts, family celebrations, food, clothing, culturally specific items, and other financial needs of their children and grandchildren.

Revising drug felon policies also has broader impacts on communities that may include children and families. When an adult fails a drug test, they risk losing benefits. This puts the ability pay for rent, utilities and other critical basic needs at risk, exposing the household to the risk of unstable housing and other crises.

Equity and Inclusion:

Cash assistance programs reflect Minnesota's racial and economic disparities. According to the Deep Poverty report, most Minnesotans living in deep poverty are White, primarily because they comprise nearly 80% of the state's population. Although Whites may make up the majority of individuals living in deep poverty, they also have the lowest rate of living in deep poverty (3.3%). This contrasts with the 16% of American Indians and 13% of Blacks in Minnesota living in deep poverty, the highest rates of any racial group.

Homelessness disproportionately impacts people of color and American Indians in Minnesota as well. According to the most recent Wilder Research report, African Americans make up 39% of homeless adults, while being only 6.8% of the overall state population. American Indians make up 8% of homeless adults, despite being only 1% of the statewide population. The provisions in this proposal, addressing some of the state's public assistance programs that assist people who are at risk of homelessness or deep, entrenched poverty, are intended at addressing some of these disparities moving forward.

Revising drug felon policies would help eliminate disparities for Minnesotans of color. Members of those populations are more likely to be arrested, denied bail, incarcerated, and have their probation revoked than their White counterparts. Research shows that racial disparities in the Minnesota criminal justice system cannot be attributed to crime commission rates alone. Minnesotans of color commit drug offenses at the same rates as White Minnesotans. In 2015, 9.4% of White Minnesotans and 10% of Black Minnesotans reported using marijuana during the past year. In 2011, Black Minnesotans were 6.4 times more likely to be arrested for marijuana possession than White Minnesotans. Over half of the drug offenders in Minnesota prisons are African American, American Indian, Asian, and Hispanic as compared to 21 percent of state residents that are people of color or American Indian. This makes these populations more vulnerable to losing their benefits because of the current policy on random drug testing. Whites, however, are the largest number of people testing positive due to random drug testing.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Increasing the time for a person receiving General Assistance and/or Housing Support to apply for Supplemental Security Income (SSI), from 30 days to 90 days would relieve tribes of the burden of the administrative complexity involved with issuing benefits and then denying benefits after 30 days because a recipient was not able to meet with their local Social Security Administration staff for an interview. Tribes would be able to make use of DHS' "good cause" provision and allow recipients more time to apply for SSI benefits.

Revising felon policies would relieve tribes of the burden of conducting random drug testing. It would also relieve them of the administrative complexity involved with figuring out how to implement the complicated provisions of the current law. It can be very difficult for agencies to accurately determine whether an individual is subject to the drug felon provisions, because public information about drug felony convictions does not indicate when (or whether) a person has completed the terms of their court-ordered sentence. Revision of these policies would also result in tribes no longer needing to end benefits for people otherwise eligible for cash assistance. There would also be far fewer appeals about drug felon policies.

This proposal was discussed at the annual DHS Tribal Legislative summit. DHS presented our housing and economic assistance proposals at the October Tribal Collaborative meeting, held in the Fond du Lac Nation.

Impacts to Counties:

Increasing the benefit amount for General Assistance and increasing the window of time in which people can apply for other benefits is not anticipated to have a fiscal impact on counties.

Increasing the time for a person receiving General Assistance and/or Housing Support to apply for Supplemental Security Income (SSI), from 30 days to 90 days would relieve counties of the burden of the administrative complexity involved with issuing benefits and then denying benefits after 30 days because a recipient was not able to meet with their local Social Security Administration staff for an interview. Counties would be able to make use of DHS' "good cause" provision and allow recipients more time to apply for SSI benefits.

Revising felon policies would relieve counties of the burden of conducting random drug testing. It would also relieve them of the administrative complexity involved with figuring out how to implement the complicated

provisions of the current law. It can be very difficult for agencies to accurately determine whether an individual is subject to the drug felon provisions, because public information about drug felony convictions does not indicate when (or whether) a person has completed the terms of their court-ordered sentence. Revision of these policies would also result in counties no longer needing to end benefits for people otherwise eligible for cash assistance. There would also be far fewer appeals about drug felon policies.

IT Costs:

Changes are required to the MAXIS system to modify the Housing Support person cooperation test to reflect this change in policy. No changes are required in MAXIS for the General Assistance program as this program is not automated.

Changes are required to the MAXIS system to implement alignment of the General Assistance (GA) community living benefit standard with the MFIP program and it's annual COLA increases. These systems changes are estimated to require 1,542 hours of work, take approximately 9 months to complete, and cost of a total of $165,838 for initial development and $33,168 per year ongoing.

Results:

Increasing the benefit amount for General Assistance General Assistance serves some of the poorest people in the state. By increasing the benefit amount, which has not increased since 1986, and tying the amount to the Minnesota Family Investment Program single person assistance standard, the state will be able to measure if these changes have improved the general quality of life for program recipients.

Extending the window for General Assistance or Housing Support recipients to apply for Social Security disability benefits The Department of Human Services will analyze if this change increases the number of applicants who are successfully able to connect with a Social Security advocate. In addition, DHS will analyze if this increases the number of successful applicants for Social Security disability benefits.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			185	21,474	21,659	29,983	31,100	61,083
HCAF								
Federal TANF								
Other Fund								
Total All Funds			185	21,474	21,659	29,983	31,100	61,083
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	23	General Assistance Grants	0	21,355	21,355	29,863	30,978	60,841
GF	11	MNIT-Align GA Benefit Level to MFIP-55% state share	77	15	92	15	15	30
GF	11	MNIT – MAXIS- 55% state share- apply for SSIS benefits	14	3	16	3	3	6
GF	21	Eliminate drug testing- MFIP/DWRP	30	31	61	31	32	63
GF	23	Eliminate Drug testing- General assistance	46	50	96	51	51	102
GF	24	Eliminate drug testing- MSA	18	20	38	20	21	42
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
			0	0		0	0	

Statutory Change(s):

256D, 260D, 256P

Change Item Title: Increasing Wages and Workforce Participation for People with Disabilities

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	1,951	6,025	5,911	5,437
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	1,951	6,025	5,911	5,437
FTEs	**7.25**	**7.25**	**7.25**	**7.25**

Recommendation:

The Governor recommends reforms and investments that align Minnesota's disability service system with Employment First policies, and renew the State's commitment to ensuring people with disabilities have access to competitive, integrated employment opportunities.

This proposal invests $7.976 million in fiscal years 2024-25 and $11.348 million in fiscal years 2026-27. It includes the following investments and reforms:

- Lead Agency Employment Capacity-Building Grants;
- Required Case Manager Employment Training;
- Funding for a statewide Disability Employment Technical Assistance Center;
- Embedded employment resources in MnCHOICES Assessment and Support Plan;
- Policy changes to informed choice laws;
- Phasing out the use of subminimum wages in waiver services;
- Interagency alignment study and data sharing;
- Administrative resources to establish transition age youth supports coordinator and additional support for employment programs;
- Removal of a work disincentive from Minnesota Supplemental Aid (MSA);
- Enhanced system to track outcomes for people being paid subminimum wage;
- Disability inclusive worksite training and certification; and
- Creation of a preferred contractor designation for disability inclusive worksites for the State of Minnesota.

Rationale/Background:

Throughout American history, people with disabilities have faced discrimination and barriers in obtaining and maintaining jobs. Despite the passage of monumental disability non-discrimination laws, discrimination still exists today. Employees with disabilities are more likely to start in entry level positions, more likely to stay in lower paying positions, and have fewer opportunities for career advancement. People with disabilities also report less favorable attitudes and experiences and work, including perceptions of fairness, less organizational support, and lower quality relationships with managers.

"Employment First" is a concept that embodies the expectation that all working age Minnesotans with disabilities can work, want to work, and can achieve competitive integrated employment; and that each person will be offered the opportunity to work and earn a competitive wage before being offered other supports and services. Employment First is nationally recognized as a policy path toward greater community employment. In 2014, the

Olmstead Subcabinet adopted the Minnesota Employment First Policy. There are four guiding values of Minnesota's Employment First vision:

1. Employment is the first and expected outcome for working-age people with disabilities, including those with complex and significant disabilities.
2. People with disabilities are competitively employed or self-employed.
3. Employees with disabilities earn at least the minimum wage and benefits.
4. Employee with disabilities are fully integrated into the workplace and interact with coworkers, customers, and the public.

Minnesota's Employment First policy has led to important policy advancements and policy guidance. In 2018, Minnesota added three new employment services to home and community-based waivers: employment exploration, employment development, and employment support. These services support competitive, integrated employment for people with disabilities. They include new, more individualized services tailored to meet a person's support needs, dreams, and unique circumstances. In 2020, Minnesota followed the direction of other states, codifying its Employment First policy in law.

Many inequities that people with disabilities still face today are the result of an outdated government model that promotes segregation and limits independence through programs and policies that often force people with disabilities to choose between health care and the ability to work and save money, and that allow providers to pay subminimum wages to people with disabilities. Despite national efforts to raise the federal minimum wage, Section 14(c) of the federal Fair Labor Standards Act (FLSA) allows employers to pay wages less than the federal minimum wage to workers who have disabilities. Passed in 1938, this law was intended to provide job opportunities to people with disabilities unable to find work in the competitive job market. While at least 15 states have banned the use of subminimum wage for people with disabilities, Minnesota has the highest reliance of subminimum wage than any other state in the nation.

The 2021 Minnesota Legislature created the Task Force on Subminimum Wages (Minnesota Laws 2021, 1st Special Session, Chapter 7, Article 17 section 14) to develop a plan and make recommendations to phase out payment of subminimum wages to people with disabilities on or before August 1, 2025. This proposal aligns with task force recommendations.

Proposal:

This proposal includes a comprehensive package of investments and policy reforms that, together, will increase wages for people with disabilities, create more inclusive worksites for people with disabilities, address workforce shortages, and increase labor force participation by people with disabilities. The proposal is divided into five categorical system gaps, with specific strategies tied to each category.

1. Capacity building – Technical Assistance and Training

Through administering the Task Force on Eliminating Subminimum Wages and carrying out associated public engagement, DHS identified (1) significant gaps exist in people/families being able to understand and navigate employment service options, (2) a need to improve as well as build regional consistency in case management services and supports available to case managers, and (3) a continued need for technical assistance to support all partners in the state's disability employment supports system to transform business models, support community inclusion, and improve competitive, integrated employment for people with disabilities. To address these learnings, this proposal would: establish Lead Agency Employment Capacity Building Grants, require additional case manager employment training, and fund a statewide disability employment technical assistance center.

2. Individual education, information and support

Through administering the Task Force on Eliminating Subminimum Wages and carrying out associated public engagement, DHS has identified (1) significant gaps exist in people/families understanding available employment

service options and work incentives and (2) concerns about the impact of work on benefits are a barrier for many in pursuing competitive employment. This proposal addresses these gaps by: embedding employment resources in the MnCHOICES Assessment and Support Plan and updating employment policy statements in statute to include benefits planning assistance as part of the informed choice process for people with disabilities when considering employment options.

3. Service alignment and inter-agency collaboration

Through administering the Task Force on Eliminating Subminimum Wages and carrying out associated public engagement, DHS has identified that (1) there is inconsistency across the employment supports for people with disabilities administered by DHS, MDE, and DEED that create complexity, confusion, and potentially unintended incentives in our statewide system; (2) young adults who are graduating from school or transition programs often experience inconsistent supports or explanations of those supports across the state and across programs during this critical time in establishing an employment trajectory; and (3) a work disincentive exists in Minnesota Supplemental Aid (MSA) whereby people receiving MSA Housing Assistance who work, and earn enough to accrue Social Security work quarters, work their way off of SSI and switch to Social Security Disability Insurance (SSDI). In doing so, their income often becomes too high to qualify for MSA, but often not high enough to make up the difference of losing the MSA Housing Assistance benefit.

Additionally, Minnesota offers three waiver employment services to help people engage in, plan for, and keep employment (exploration, development and support services). Employment exploration and development services require that the employment the person is engaging in or planning for pays a competitive wage and is integrated in community settings. Employment support services only requires that the employment the person is keeping is in a community setting, but allows for people to be paid non-competitive wages. In addition, Minnesota offers prevocational wavier services. Prevocational services teach people essential work skills and strengthen their work capacity to meet the demands of work. These services develop necessary and marketable work skills and abilities that lead to greater opportunities for competitive, community employment. The use of subminimum wages in the employment and prevocational services is inconsistent with Minnesota's Employment First Policy and goals of helping people achieve competitive employment.

To address these issues, this proposal would phase out the use of subminimum wages in disability waiver services, establish a transition age youth supports coordinator, fund an Interagency Employment Supports Alignment Study, and remove the work disincentive from Minnesota Supplemental Aid (MSA).

4. Data and performance

Minnesota lacks reliable data on the use of subminimum wages in the state as well as the competitive employment outcomes of people with disabilities who are being served in Medicaid programs. This lack of information makes it difficult to identify outcomes for people exiting subminimum wages and if programs and services designed to support people with disabilities in engaging with, planning for, finding, and keeping competitive employment are effective. Through data sharing across state agencies, Minnesota can track employment outcomes for people receiving Medicaid services, but tracking outcomes for people receiving subminimum wages will require a unique data collection system.

This proposal will improve data and performance measures by: establishing a data system to track outcomes for people being paid subminimum wages, allowing for administrative data sharing for employment outcome monitoring, and assign staff resources to use data to improve employment programs.

5. Business engagement

Through administering the Task Force on Eliminating Subminimum Wages and carrying out associated public engagement, DHS has identified that (1) families of people with disabilities earning subminimum wages are concerned about the safety and inclusivity of community businesses as people transition to competitive

employment and (2) partners across the state see a need to engage as well as educate community businesses regarding employment of people with disabilities and incentives to encourage employers to be inclusive worksites. To address these issues, this proposal: establishes a disability inclusive worksite training and certification and creates a preferred contractor designation for disability inclusive worksites.

Impact on Children and Families:

This proposal will help families of children with disabilities realize a more economically and socially inclusive future for their loved ones by strengthening the rights of and supports for people with disabilities to be competitively employed.

Equity and Inclusion:

Nationally, people with disabilities have the highest rates of poverty of any subcategory of Americans identified by the Census Bureau. In Minnesota, as of FY21, only 16% of people receiving HCBS disability waiver services have $600 or more in monthly income, a proxy measure used for participation in competitive employment. This is a 2% decrease from FY20. As of November 2020, despite being less populated than about half of the country, Minnesota had the most workers paid at subminimum in the nation. Increasing wages and labor market participation for people with disabilities can be a ladder out of poverty. People living in poverty are at increased risk for mental illness, chronic disease, higher mortality, and lower life expectancy. Poverty creates barriers to stable housing, healthy food, and quality education.

This proposal advances the civil rights and economic inclusion of people with disabilities in Minnesota through expanding statewide infrastructure to support people with disabilities in competitive employment and limiting the use of subminimum wages in HCBS waiver employment services. This proposal answers the call of self-advocates with disabilities who pushed the legislature in 2021 to develop a Task Force on Eliminating Subminimum Wages and develop a plan to end the practice in the state.

Minnesota currently has the highest rate of subminimum wage use among any state in the nation[1]. There are significant concerns about the use of subminimum wages from a civil rights as well as an efficacy perspective, including multiple national bodies recommending an end to the practice and a 2020 US Commission on Civil Rights report finding the practice contributes to the segregation of people with disabilities and recommending phase out. According to Minnesota's Employment First Dashboards, as of fiscal year 2021, only 11% of people receiving HCBS disability waiver day or employment services participate in competitive employment. Contrasted with an overall unemployment rate of 3.4% in Minnesota, this data shows that people with disabilities are significantly underrepresented in the competitive workforce.

Furthermore, people of color in Minnesota who receive waiver services participate in employment services at a lower rate than their white counterparts. When looking at Long Term Services and Supports Demographics Dashboard data from January 2021, 20% of waiver recipients identified as Black, but only 10% of people on waivers served by Vocational Rehabilitation Services (who provide job search supports) were Black. Conversely, we see an overrepresentation of White people. In January 2021, 59% of waiver recipients identified as white, but 73% of people on waivers served by VRS/SSB were white. According to January 2018 data from the DHS competitive employment performance dashboard, 12% of people who identify as white on HCBS disability waivers are estimated to be competitively employed, whereas 8% of people who identify as African American/Black on HCBS disability waivers are estimated to be competitively employed and 7% of people who identify as American Indian on HCBS disability waivers are estimated to be competitively employed.

[1] MAD used US DOL data for workers paid subminimum wages from the listing of 14(c) certificate holders as of October 2021 and divided those counts by overall state populations for July 2021 from the Census Bureau to calculate the state data on persons paid subminimum wages as a proportion of each state's population. This adjustment for population allows for reasonable comparisons among states of different population sizes.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
This proposal provides additional resources, tools, and supports to counties to meet current expectations in advancing employment first and support planning for people with disabilities. These will be large impacts. This proposal adds training requirements for case managers employed or contracted by counties. This proposal will reduce disparities in regional employment capacity among counties by creating regional supports and standardized resources.

IT Costs

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll	0	0	0	0	0	0
Professional/Technical Contracts	38	75	75	0	0	0
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)						
Total	38	75	75	0	0	0
MNIT FTEs	0	0	0	0	0	0
Agency FTEs	0	0	0	0	0	0

Results:
This proposal will result in no one who receives home and community-based services receiving subminimum wage by August 1, 2028. To support this transition, this proposal is expected to increase Minnesota's capacity to support competitive integrated employment goals and improve outcomes, create a mandated training for case managers and improve engagement between people with disabilities and Minnesota businesses.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	The number of people receiving subminimum wage in home and community based services will be reduced to 0	An estimated 4,500-6,000 people receive subminimum wage in Minnesota, but not all are receiving HCBS		August 1, 2028
Quality	100% of Case Managers will complete mandated training, supporting the transition to competitive employment and creating consistent	0 Case managers have received this training in the past		January 1, 2028
Results				

Fiscal Detail:

Summary of proposal component costs:

Proposal Component	Component Detail	FY 2024	FY 2025	FY 2026	FY 2027
1) Capacity Building	Employment and TA Center grant $1.8m annually, lead agency capacity building grants $500k initially and $2.5m annually, SELN case manager training $249k over 4 years, and 3 FTE contract manager, Professional Toolkit Manager, and Central Operations related contract review and financial payment costs.	1,170	4,751	4,673	4,673
2) Individual Education, information, and support	MnCHOICES system enhancements, and employment campaign and resources development and printing and translation P/T contract costs of $1.275m over 4 years	288	525	525	125
3) Service Alignment and inter-agency collaboration	P/T Contractor costs of $340k over 4 years for study and help E1MN implement priority agreements, and 1 FTE youth in transition coordinator.	130	248	214	180
4) Data and Performance	Data systems license and administration, and 2.25 FTE to support work including partner performance lead, program integrity specialist, and lead agency review	188	261	290	287
5) Business Engagement	Training/certifications process development and communications P/T contract $408k over 4 years, and 1 FTE project manager and certification administrator	175	240	208	172
Total		**1,951**	**6,025**	**5,910**	**5,437**

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			1,951	6,025	7,976	5,911	5,437	11,348
HCAF								
Federal TANF								
Other Fund								
Total All Funds			1,951	6,025	7,976	5,911	5,437	11,348
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	55	Employment and TA Center Grant	450	1,800	2,250	1,800	1,800	3,600
GF	55	Lead Agency Capacity Building Grants	500	2,500	3,000	2,500	2,500	5,000
GF	55	SELN Case Management Training Grants	37	123	160	45	45	89
GF	14	MAPE 11 FTE (2,2,2,2) Admin	128	318	446	318	318	636
GF	11	MAPE 17 FTE (1,2,2,1) Central operations	141	165	306	165	165	330
GF	REV1	Admin FFP @32%	(86)	(155)	(241)	(155)	(155)	(309)
GF	11	MNChoices Systems Enhancement	38	75	113	75	0	75
GF	55	Employment campaign and resources development	250	450	700	450	125	575
GF	14	Admin E1MN Implementation P/T Contract	50	200	250	150	100	250
GF	REV1	Administrative FFP @32%	(16)	(64)	(80)	(48)	(32)	(80)
GF	14	Administrative MAPE 17 FTE (1, 1, 1, 1) - Youth in Transition Coordinator	141	165	306	165	165	330
GF	REV1	Administrative FFP @32%	(45)	(53)	(98)	(53)	(53)	(106)
GF	11	Systems - Data systems license	45	45	90	45	45	90
GF	14	ADSA Admin FTE (2.25,2.25,2.25,2.25)	210	318	528	361	356	717
GF	REV1	Admin FFP @32%	(67)	(102)	(169)	(115)	(114)	(229)
GF	14	Training and Comm Plan P/T/ Contract	102	136	238	102	68	170
GF	14	Administrative MAPE 14 FTE (1, 1, 1, 1) - Project Manager and certification admin	107	153	260	156	153	309
GF	REV1	Admin FFP @32%	(34)	(49)	(83)	(50)	(49)	(99)
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	14	ADSA Admin	6.25	6.25	6.25	6.25	6.25	6.25
GF	11	Central Ops Admin	1	1	1	1	1	1

Statutory Change(s):

Session law

Change Item Title: Critical Resources for Licensing

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	5,556	6,431	6,757	6,954
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	5,556	6,431	6,757	6,954
FTEs	**57**	**60**	**63**	**65**

Recommendation:
The Governor recommends investments to strengthen core functions of licensing, which includes licensing and oversight of home and community-based services (HCBS), child and adult foster care, and child care centers; maltreatment investigations; and the department's responses to urgent program needs to ensure continuity of services for vulnerable adults and children.

The Licensing Division in the Office of Inspector General performs a critical role in ensuring the health and safety of the vulnerable adults and children receiving services through licensing reviews and maltreatment investigations. Licensed programs and investigations have increased significantly while staffing has failed to keep pace with this growth.

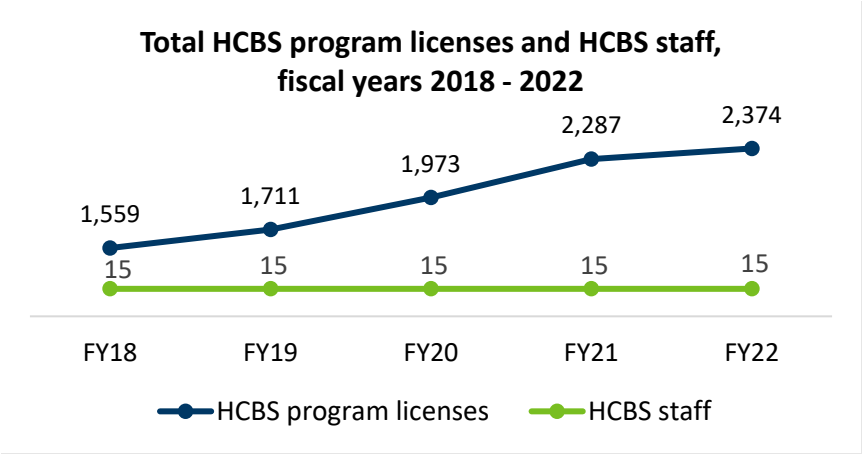
Rationale/Background:
The requested resources in this proposal are critical for the Licensing Division to carry out its mission to ensure program integrity and the health and safety of vulnerable adults and children.

HCBS
The increasing complexity of HCBS service plans, waiver plans, the needs of the persons served, and increased licensing sanctions against providers have increased the demands on the Licensing Division. Since the inception of HCBS licensed services on January 1, 2014, the number of services has expanded from 19 to 31. The number of license holders has also increased significantly from 1,283 at the end of FY 2015 to 2,374 licenses at the end of FY 2022 – a growth of 85 percent – and the number continues to increase while staffing has remained the same. The amount of time to review applications has also increased, from an average of 27 weekdays in FY 2017 to an average of 164 weekdays in FY 2022. Licensed providers deliver services to approximately 59,000 older adults and people with disabilities in more than 4,900 licensed settings or in the service recipient's own home or community.

Not only have the numbers of providers and persons served increased, but the level of detail required to conduct the reviews and analyze compliance is demanding. With current staffing levels, licensors only monitor providers' compliance an average of once every 4.5 years, unless a history of noncompliance warrants additional licensing reviews. A significant increase in applications in the past two years will continue to increase the interval period between licensing reviews. This falls far short of the federal waiver plan, which binds the State to conducting reviews at least once every three years.

Complaints about licensing violations, including severe violations, have become more complex. The average amount of time it takes to complete a licensing investigation has increased by 236 percent from 47 days in FY

2016 to 158 days in FY 2021. The Licensing Division is struggling to meet the demands of investigating complaints while also staying current on scheduled monitoring reviews.



Foster Care

The number of license holders serving children in family foster care settings has grown significantly in recent years. Since 2015, the total number of family child foster care licenses has increased by approximately 40 percent (from 3,119 to 4,353). Whenever possible, children are placed in unlicensed emergency relative homes, which are then required to apply for a child foster care license. The majority of family foster care license holders (57 percent) are now foster care providers who serve relative children. The number of relative-only child foster care license holders has increased by nearly 160 percent (from 545 to 1,415) since 2015. DHS also has oversight of child foster residence settings.

The dramatic increase in child foster care licenses, especially relative child foster care license holders, has put significant pressures on the DHS Licensing Division, which oversees the statewide child foster care and adult foster care licensing systems, issues foster care licenses based on agency recommendations, reviews county and private agency license denial and sanction recommendations, issues licensing sanctions, reviews/approves certain variances, and conducts regular monitoring of each county and private agency's licensing work to ensure statewide consistency of the foster care licensing system. Each licensing action involves significant case consultation with the licensing agency to assess whether the nature, severity, and chronicity of licensing violations justifies the recommendation and to ensure there is thorough documentation to support the action. In 2021, the average length of time for DHS to issue a decision on a family child foster care licensing action recommendation was 172 days.

DHS also provides training, technical assistance, and individual case consultations to approximately 400 county and private agency licensors. Relative child foster care applicants often face challenges and barriers in meeting licensing and background study requirements, which has also increased the need for DHS to provide case specific consultation and technical assistance. Additionally, the recent child foster care background studies reform and the development of child foster care licensing guidelines are changing how licensors do their work. While the number of child foster care applications and licenses has grown significantly in recent years, there has not been a corresponding increase in the number of employees doing this work.

The foster care unit is also responsible for oversight of the statewide adult foster care licensing system and the county delegated responsibilities of inspecting and monitoring community residential settings. The adult foster care licensing model has evolved significantly since the implementation of the corporate foster care moratorium in 2009 and the subsequent implementation of HCBS in 2014. Within its current staffing levels, the department is unable to provide the level of oversight and support needed for these settings. Licensors need more resources, tools, technical assistance, and trainings to help them navigate complex issues that have emerged in adult foster

care. Additional staff are needed to allow the department to fulfill its critical oversight role and resume conducting community residential setting file reviews, and complete both these and adult foster care file reviews statewide on a biennial schedule.

Maltreatment investigations

The Central Intake and Maltreatment Investigations unit triages and investigates maltreatment and licensing complaints under a combination of the Vulnerable Adults Act, the Maltreatment of Minors Act, and state licensure laws. The number of maltreatment complaints received by the Licensing Division increased by 65 percent from 4,346 in FY 2017 to 7,122 in FY 2022.

Over the period of FY 2018 – FY 2022, the Licensing Division experienced a significant increase in work, including:

- 53 percent increase in licenses
- 62 percent increase in maltreatment, licensing, and death reports received

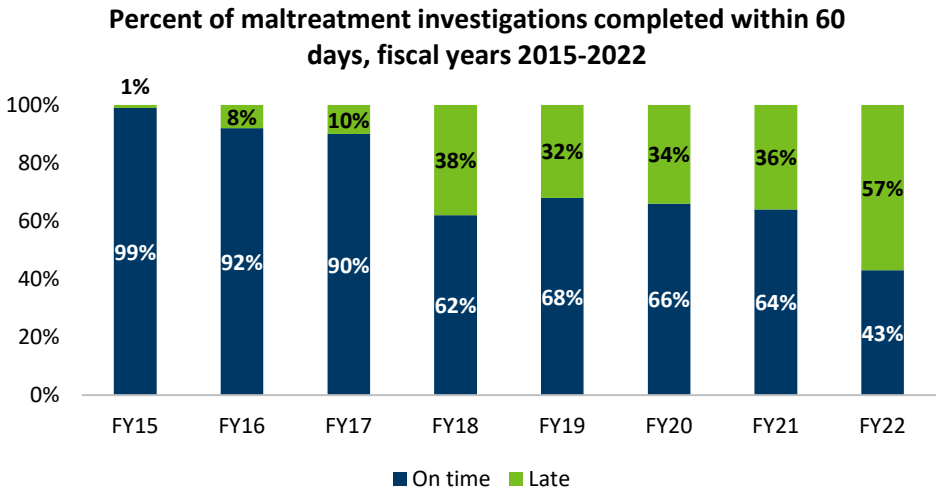
Statewide staffing shortages in programs have increased the number of reports Licensing has received and made it more difficult to gather information from staff working at those programs. DHS Licensing has also taken on investigations for Department of Corrections licensed children's residential facilities and specialized assessments for the Minnesota Security Hospital, the Minnesota Sex Offender Program, and psychiatric residential treatment facilities, further adding to the Division's work.

The Central Intake and Maltreatment Investigations unit is receiving maltreatment reports that are more complex and that require more staff time. This is affecting this unit in several ways:

- Providers frequently provide multiple lines of services, so assessors have to research databases and make phone calls to verify which services the client was receiving to verify that the investigation is within the Department's jurisdiction. Additionally, several services are regulated by more than one agency, which requires intake and assessor staff to notify and coordinate documentation with other agencies.
- There has been an increase in litigation by providers that has resulted in delays and multiple visits to programs when legal counsel for the providers can be present.
- The complexity and number of maltreatment investigations is increasing, requiring investigators to spend additional time gathering information, interviewing individuals, and coordinating with other agencies, such as law enforcement.
- Staff are required to enter each allegation into more data systems, which produces better data, but creates more work and adds complexity.

The timely review of these complaints, the researching of prior facility history, and the evaluation of maltreatment or licensing jurisdiction have all been compromised by the significant increase in reports. Statute requires that DHS make an initial disposition on every report within five business days. The percent of reports assessed within five days has fallen to 40 percent, due to the increased workloads and complexities already highlighted.

State statute requires out-of-office investigations to be completed within 60 days. The increased volume and complexity of maltreatment complaints have contributed to the Licensing Division falling behind and completing only 43 percent of out-of-office investigations within the required 60 days. Without more staff, the unit will continue to miss statutory timelines.



Child Care Centers

The Child Care Development Block Grant (CCDBG) requires every licensed child care program receive an inspection annually for compliance with licensing standards. When this new federal requirement was enacted, the DHS Licensing Division received resources to hire additional child care center licensors. The Licensing Division established a staffing plan in 2014 based on the number of licensed centers at that time, anticipated growth in the number of providers, and the target caseload number.

In 2019, the department received resources to establish a team of "early and often" child care licensors whose caseload is smaller and focused on assisting child care center applicants to become licensed and visiting newly licensed programs four times within their first year of operation. This team also works closely with the OIG Child Care Provider Investigation unit and provides a critical program integrity function.

The resources the Licensing Division has previously received have allowed the department to provide support to license holders, oversight of licensed child care centers, and meet federal CCDBG requirements for annual inspections. However, the current staffing composition is no longer sufficient to meet the needs. The number of licensed child care centers has grown steadily since 2014. Additionally, there are currently several child care capacity-building initiatives underway across state government to grow the number of child care providers to address the child care shortage, such as Child Care Wayfinder, a one-stop navigation network for starting and growing child care programs, and Empower to Educate, a child care workforce development program. These efforts collectively are working toward the One Minnesota Goal of increasing the number of families in Minnesota with adequate access to child care from 75 percent to 91 percent. Other entities around the state are also working to build child care capacity including the Minnesota Initiative Foundations, economic development professionals, and many communities throughout greater Minnesota.

DHS anticipates that these initiatives will further increase the number of licensed child care centers. The average child care center licensor caseload is currently 84 centers, and growing. As of August 24, 2022, there are 101 pending child care center license applications.

Receivership & TIS Authority for Residential Programs

This proposal will provide a mechanism to ensure vulnerable adults and children are not at risk of sudden service interruption, including the ability to remain safely in their current placement. The proposal aligns the DHS receivership process with that of the Minnesota Department of Health (MDH). This will ensure persons served can be protected in the short-term while also allowing sufficient time to locate alternative services and person-centered planning should their current service provider be unable to continue serving their needs.

Licensing is required to issue an order of temporary immediate suspension (TIS) when it is determined that conditions in a licensed program pose an imminent risk of harm to the health, safety, or rights of persons served by the program. A TIS could also be issued if a program continues to operate pending an Order of License Revocation, but Licensing determines the program has subsequent violations that adversely affect the health and safety of persons served. The effect of this order is to require a provider to immediately cease operations. For residential programs, particularly sizable programs, finding immediate person-centered alternative placements is a significant barrier to use of the TIS authority to address safety concerns. When persons served reside in the program, it is extremely difficult to ensure for the continuity of necessary services or secure alternative services immediately. This proposal would allow a planning period for the suspension to go into effect in order to transition vulnerable adults or children to alternative placements or to pursue emergency receivership over the current program. During this period, Licensing would provide enhanced oversight of the program subject to the TIS while simultaneously working with case managers and persons served to secure alternative services and/or pursue receivership. Once alternative services have been identified and implemented, the suspension order would become effective.

Additionally, for license holders that have multiple satellite or affiliated licenses connected to the larger provider organization, the current TIS statute does not allow for DHS to take site-specific actions. For example, it is common for a parent 245D license holder to hold numerous individual Community Residential Setting ("CRS") licenses that are connected to the parent license. If DHS determines that conditions in only one CRS home rise to the level of an imminent risk of harm to persons served, but other CRS homes remain in good standing, DHS cannot limit the TIS order to the individual problem site. Under current law, the parent license must be included in a TIS action. This leaves DHS with only two options: take the TIS action, unnecessarily impacting homes where persons served are *not* at an imminent risk of harm; or take no action, leaving DHS without the TIS option to address the specific program, potentially leaving persons served at risk. By comparison, there is statutory authority to issue a site-specific Correction Order or Conditional License Order under Minnesota Statutes, section 245A.06, subdivision 2a. This proposal would grant DHS the authority to take a similar action when persons served are at an imminent risk of harm in a specific service site. The benefit of this proposal would be to give DHS the tools to immediately respond to address serious licensing violations that are putting individuals at risk of imminent harm, while minimizing the disruption of programs that are not exhibiting those same violations.

Proposal

This proposal would be used to hire new staff to provide critical support to HCBS, foster care, and child care center licensing activities; maltreatment and licensing complaint investigations; and to cover costs associated with receivership.

<u>HCBS</u>

The additional funding in this proposal increases staffing in the HCBS unit within the Licensing Division at DHS by 26 FTEs for the FY24-25 biennium. The total staffing increase after the FY26-27 biennium would be 31 FTEs. This funding will ensure:

- On-site reviews of each HCBS license holder are conducted at least once every three years to meet federal waiver plan timeframes
- Staff will have greater capacity to respond to requests more quickly, including: providing technical assistance and training, application reviews and approvals, complaint investigations, and sanction activity related to providers with significant compliance issues
- Staff will have more time to communicate with providers to correct problems and improve care

To put all of this in context, Medicaid spending on licensed HCBS services in Minnesota totaled $2.1 billion in calendar year 2021. The HCBS licensing and investigation units provide quality assurance by ensuring that the services meet minimum standards, currently costing approximately $6.0 million per year – just over a quarter of one percent of the cost of the services provided. Even with the increase in funding included in this proposal, the

HCBS licensing functions would still cost just over 0.4 percent of the amount of public funds spent on providing these services.

Foster care

This proposal will add 12.0 FTE to the DHS Licensing Division to meet the increased workload attributed to the overall growth in the number of child foster care licenses and increased focus on licensing relatives, the increased complexity of emerging issues in adult foster care, and new child foster care initiatives. This funding will ensure:

- DHS Licensing staff can decrease the length of time it takes to issue licenses, license denials, licensing actions and variances;
- Staff can provide more resources, training, support, and communication to counties and private agencies;
- Staff will be able to offer technical assistance and individual case consultation to support counties and private agencies as they assist applicants; and
- Staff will have the capacity to conduct routine on-site reviews of county delegated licensing activities for adult foster care and community residential settings, and more timely on-site reviews of private agency child foster care licensing activities.

Maltreatment investigations

The additional funding in this proposal increases staffing in the Central Intake and Maltreatment Investigations unit within the Licensing Division at DHS by 12 FTE. This funding will ensure:

- Intake and assessor staff have time to adequately research and review licensing and maltreatment complaints, including completion of a robust, in-office investigation within statutorily required timelines;
- Maltreatment investigators can conduct out-of-office investigations of ever more complex maltreatment complaints within statutorily required deadlines; and
- Staff have more time to communicate with families and help providers correct problems and improve care.

Child Care Centers

This proposal will add seven FTE to the Child Care Center Licensing unit. This funding will ensure:

- Compliance with the federal Child Care Development Block Grant requirement for annual visits;
- Licensors can maintain a caseload size of 75-80 centers and be a resource for providers who have questions or need technical assistance; and
- The “Early and Often” team of child care licensors will continue to be able to focus on supporting and providing oversight to applicants and newly licensed child care centers.

Receivership & TIS Authority for Residential Programs

This proposal will provide DHS with the necessary tools to quickly and effectively address imminent health and safety concerns without a loss of services for vulnerable adults and children who live in residential programs. The proposal includes two prongs: (1) aligning DHS’ receivership language with that of our partner agency, MDH, which has refined its receivership authority based on extensive experience with nursing home receiverships, and (2) amending DHS’ temporary immediate suspension (TIS) authority so that it can be used more effectively in ensuring continuity of services for vulnerable adults and children.

The receivership component of this proposal establishes DHS’ authority to operate and re-license or close programs that have placed clients in imminent risk of harm. It adjusts receivership timelines, establishes a funding mechanism for instances of receivership, limits liability of managing agents, sets criteria for termination of the receivership, and establishes a period of financial reconciliation with the managing agent so that monies advanced in excess of need are returned to DHS.

The proposal would address associated litigation costs required to petition the court and represent DHS in the proceedings and the costs of receivership itself, including administrative fees for a third-party managing entity

that will conduct the day-to-day operations of the program under receivership and bear primary responsibility for winding down of the program. $1 million is recommended to support these expenses in FY 2024.

Receivership, if granted, results in the commissioner assuming operations of a program. The commissioner would contract with a managing agent to carry out the day-to-day operations, but the court would order the commissioner to pay a fee and cover costs of those operations. These fees could be significant depending on the size, conditions and circumstances facing the individual program.

This proposal also enhances DHS' TIS authority so that the licensing status of a license holder who is subject to receivership reflects that the program is in receivership due to imminent risk of harm to clients. A TIS requires the immediate closure of a license. For residential programs, particularly sizable programs, finding immediate person-centered alternative placements is a significant barrier to use of the TIS authority to address safety concerns. This proposal would allow a planning period for the TIS to go into effect in order to transition vulnerable adults or children to alternative placements or to pursue emergency receivership over the current program. During this period, licensing would provide enhanced oversight of the program subject to the TIS while simultaneously working with case managers and persons served to secure alternative services and/or pursue receivership. Once alternative services have been identified and implemented, the suspension order would become effective.

Currently, when DHS revokes a license, any other licenses held by the license holder or that have common controlling individuals must also be revoked. Under this proposal, if the other licenses are in substantial compliance and provide services relied upon by the community, DHS can choose not to issue a revocation of those affiliated licenses. The effect of this proposal would allow quality programs that can be distinguished from those that were revoked, to remain active and providing necessary services.

Data and Analytics Office

This proposal will add two FTE to the Data and Analytics Office to support the data and analytic needs of the Licensing Division to assure the health and safety of the vulnerable adults and children receiving services. The addition of these staff will enable the Data and Analytics Office to:

- Create and maintain dashboards to track performance and decrease the time it takes to obtain data to make critical decisions for the Central Intake and Maltreatment Investigations unit
- Respond timely to the increased number of public data requests
- Create metrics to track operational performance of the Licensing Division units
- Develop and implement data-driven models necessary to implement key indicator abbreviated checklists in a differential monitoring system to improve the efficiency of compliance monitoring
- Support the implementation of the new child care licensing and provider reporting hub to improve access to data and enable data driven decision making that promotes integrated service delivery

Enterprise Operations Office

This proposal will add one FTE to the OIG Operations Office to coordinate risk management and business continuity responsibilities within the Office of Inspector General (including the Licensing division) necessary to ensure compliance with agency and state requirements in these two areas. The growth of the OIG Licensing division proposed requires additional resources to appropriately staff this scope. The addition this staff member will enable OIG Operations to:

- Maintain up-to-date continuity of operations plans that describe OIG's critical business priorities and the resources needed to maintain services during continuity events
- Coordinate OIG's continuity event response, including working with OIG leadership, divisional business continuity planners, and the administration's Recovery Director to ensure issues and guidance are identified and communicated, prepare impact analyses, and make recommendations.
- Coordinate OIG's risk management framework, including working with OIG leadership and agency stakeholders to identify risk factors impacting OIG's business functions, identify and facilitate implementation of mitigation strategies, and report on progress.

Impact on Children and Families:
HCBS licensors monitor services provided by the waiver programs and thereby ensure that these services will be available to children and adults with disabilities who need them. Increasing the frequency of monitoring visits will help ensure that families and children are provided with services that support their independence in compliance with health and safety standards.

The increased emphasis in recent years on placing children in foster care with a relative has significantly increased the number of relatives seeking a foster care license. Relatives may face barriers to licensing and need additional support navigating the application and home study processes and sometimes need variances to licensing requirements. With additional resources, the Licensing Division will be able to provide more trainings, technical assistance, and individual case consultation to county and private agency licensors. Applications for licensure will also be processed quicker. This will assist all child foster care applicants, especially relative applicants. Relatives must be licensed for a minimum of six months in order to qualify for Northstar Kinship Assistance so licensing delays lead to delays in permanency for children, as well as relative families being able to access this resource.

Ensuring that the Department's Licensing Division has the resources it needs to manage reports of maltreatment or other licensing complaints for providers in a timely manner will better serve children, vulnerable adults, and their families. Staff will also be able to spend more time communicating with families during investigations of alleged maltreatment.

Children and families benefit from licensing oversight of child care centers. Licensing reviews ensure centers are compliant with health and safety standards and provide a safe setting for children. Proper staffing levels allow the department to provide technical assistance to applicants for licensure, process applications in a timely manner, and offer support throughout a center's first year of operation. These efforts benefit families by ensuring more child care options are readily available and, once opened, centers have the knowledge and resources to succeed.

Children and families will benefit from receivership, because it will ensure that children are not at risk of losing services due to a financial crisis or severe noncompliance by their service providers. The proposal will allow the commissioner to step in to protect children served, particularly in residential programs, by providing immediate care as well as a plan for long-term alternatives. Similarly, providing flexibility in the effective date of a TIS order while alternative resources or receivership is pursued will allow Licensing to issue an action when conditions in a program put vulnerable adults or children at risk of harm, while providing time to ensure services are not abruptly ended without a safety net.

Equity and Inclusion:
There are no anticipated negative effects for underrepresented individuals or communities. We anticipate a significant positive impact to persons receiving services as more frequent licensing activity should increase compliance with health, safety, and rights standards. It will also have a positive effect on these groups by allowing more timely responses to concerns and complaints.

BIPOC and LGBTQ communities are disproportionately represented in child foster care. In 2021, American Indian children were around 16 times more likely to experience out-of-home care, those of two or more races were seven times more likely, and Black children were approximately twice as likely as their white counterparts. Investments in the child foster care system will benefit these populations by ensuring more assistance for relatives seeking licensure, more timely responses to applications and licensing questions, and more expeditious due process.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
This proposal will not impact counties financially; however, with additional staff, DHS will be better able to support counties' foster care and community residential setting licensing work. DHS will be able to increase its engagement with county agencies by providing additional outreach, oversight, case consultation, and technical assistance. Counties may be asked to partner with Licensing in response to a TIS order for a community residential setting by providing enhanced licensing oversight during the transition period or in locating alternative services to vulnerable individuals whose residence and services are impacted by the TIS.

The Licensing Division will be able to offer statewide trainings, including new trainings to support relative applicants on a regular basis and offer more-timely updates to the licensor packet forms.

Results:

Type of Measure	***Name of Measure***	***Current***	***Projected***
Quantity	HCBS: License review cycle	4.5 years	3 years
Quantity	HCBS: Number of licensed providers visited per year	about 500 per year*	900 per year
Quantity	Foster care: Average length of time for DHS to issue a decision on a family child foster care licensing action recommendation (CY 2021)	172 days	60 days
Quantity	Foster care: Licensor trainings (CY 2019)	15	32
Quantity	Maltreatment investigations: Percentage of reports assessed within initial five days of receipt	40%	100%
Quantity	Maltreatment investigations: Percentage of maltreatment reports assigned for investigation and completed within 60 days	43%	95%
Quantity	Child care centers: Number of pre-licensing visits, early and often and annual inspections conducted (CY 2019)	1,819	2,450
Quantity	Child care centers: Number of applications submitted for licensure (average CY19-21)	116	175

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			5,556	6,431	11,987	6,757	6,954	13,711
HCAF								
Federal TANF								
Other Fund								
Total All Funds			**5,556**	**6,431**	**11,987**	**6,757**	**6,954**	**13,711**
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	Home and Community Based Services FTEs (23, 26, 29, 31)	2,554	4,107	6,661	4,587	4,876	9,463
GF	11	Foster Care FTEs (12,12,12,12)	1,594	1,841	3,435	1,841	1,841	3,682
GF	11	Intake/Maltreatment Investigations FTEs (12,12,12,12)	1,631	1,891	3,522	1,891	1,891	3,782
GF	11	Child Care Centers FTEs (7,7,7,7)	972	1,131	2,103	1,131	1,131	2,262
GF	11	Data and Analytics FTEs (2,2,2,2)	283	330	613	330	330	660
GF	11	Operations FTEs (1,1,1,1)	136	157	293	157	157	314
GF	11	Receivership Funding	1,000	0	1,000	0	0	0
GF	REV1	Admin FFP @ 32%	-2,614	-3,026	-5,640	-3,180	-3,272	-6,452
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	OIG FTEs	57	60		63	65	

Statutory Change(s):

- **Receivership:** 245A.12, 245A.13; and
- **TIS:** 245A.07, subdivision 2

Change Item Title: Addressing Homelessness for Minnesota Adults, Youth, and Families

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	25,778	30,920	45,920	45,920
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	25,778	30,920	45,920	45,920
FTEs	**10**	**10**	**10**	**10**

Recommendation:

The Governor recommends investing $56.7 million in FY 2024-2025 and $91.8 million in FY 2026-2027 from the general fund to increase base funding for the Emergency Services Program (ESP), Transitional Housing Program (THP), Homeless Youth Act (HYA), and Safe Harbor (SH). This investment includes:

- Emergency Services Program: $35 million in FY 2024-25 and $70 million in FY 2026-27 to increase base funding for ESP. This funding request increases through the FY 2026-27 biennium to accommodate the shelter operations funding that would be needed to accommodate the governor's separate capital request for new, renovated, and expanded emergency shelter facilities.
- Transitional Housing Program: $6 million in FY 2024-25 and $6 million in FY 2026-27 to increase base funding for THP.
- Homeless Youth Act: $11.2 million in FY 2024-25 and $11.2 million in FY 2026-27 to increase base funding for HYA.
- Safe Harbor Shelter and Housing: $2.5 million in FY 2024-25 and $2.5 million in FY 2026-27 to increase base funding for Safe Harbor Shelter and Housing.

The current annual base funding for these programs is $6.844 million for ESP, $3.184 million for THP, $5.619 million for HYA, and $3.5 million for Safe Harbor Shelter and Housing. This recommendation also includes modifications to the HYA Provider Repair and Improvement grant requirements and a codification of Safe Harbor Shelter and Housing grants into statute.

This proposal includes staff to administer the large increases for these programs.

Rationale/Background:

Minnesota counted 7,917 people experiencing homelessness on one night during the January 2022 point-in-time count. Of these, approximately 1,741 people were staying outside. Adults represent 62% of the population counted, families with children made up 37%, and unaccompanied children made up 1%. Statewide, providers serving individuals and families experiencing homelessness have articulated the extreme pressures facing the state's emergency safety net, and the challenges they face in providing and improving services for people experiencing homelessness. Current levels of state support for emergency shelters are not sufficient to meet the needs of individuals, families and youth experiencing homelessness, and key state programs – including ESP, THP, HYA, and SH – have funding levels that do not adequately support the critical work of providers across the state.

Emergency Services Program (ESP):

In recent years, individuals and families staying outdoors or in places not meant for human habitation has been one of the fastest growing segments of the population of Minnesotans experiencing homelessness. Roughly 2,000 Minnesotans, or 25% of people homeless at any point in time, are without shelter, and many of this group are in encampments. Existing shelter capacity is insufficient to meet statewide shelter needs. Given current shelter options and perceptions and realities about those options, some people continue to prefer sleeping outdoors to sleeping in shelter. For example, if accessing shelter requires doing so without one's chosen group of people, possessions, or pets, some opt to stay outdoors instead of accessing available shelter. Additionally, existing emergency shelter options are not meeting the needs of communities most impacted by homelessness. For example, American Indian Minnesotans are 24 times more likely to be unsheltered than white Minnesotans, and African American Minnesotans are seven times more likely.

With minimal state investment, emergency shelters have historically been understaffed with high participant-to-staff ratios. As a result, many agencies rely on volunteers with limited training and/or contract with security companies rather than trained service professionals. In addition, wages at emergency shelters lag behind other human service settings, and statewide workforce shortages and the impacts of economic inflation have meant shelters are losing staff to higher paying or lower-demand jobs, including in retail and service industries.

ESP provides emergency shelters with flexible grants that can be used to meet a variety of needs, including supporting the operating and maintenance costs of shelters, and providing essential services to people experiencing homelessness. Increased funding to the program will help emergency shelters across the state that are under financial strain. Additional funding will also support innovative and effective approaches to unsheltered homelessness and enhanced collaboration around homeless encampments between state and local governments, Tribal Nations, and community-based organizations.

Transitional Housing Program (THP):

In March 2021, DHS published a request for proposals to provide services through the Homeless Assistance Grants, which included THP. As a result, DHS received 68 applications from non-profits, local units of government, and Tribal Nations from around the state of Minnesota for rapid re-housing/scattered-site transitional housing and site-based transitional housing activities, totaling over $23 million in financial requests. These activities are currently funded with one or more available funding sources through DHS totaling $14,408,193, which highlights a $9,019,369 gap in funding for rapid re-housing/scattered-site transitional housing and site-based transitional housing activities based on applications received for the 2022-2023 biennium.

THP provides rental subsidies and supportive services to homeless individuals and families to obtain and maintain permanent, stable housing. With an increase in THP funding, the adverse effects of being homeless can be addressed to end the cycle of homelessness. An increase in THP funding would also support culturally specific transitional housing units and programming, which should help reduce the state's racial disparities in housing.

Relative to other groups of Minnesotans, people identifying as African American or American Indian are notably overrepresented in the homeless population. Racist and discriminatory economic and housing policies, along with generational poverty, continue to play a role in the overrepresentation of African American and American Indian people in the homeless population.[1] Acknowledging the lasting impact of systemic racism on current racial disparities in homelessness is an important first step towards addressing the issue. As indicated on the Racial Disparities Dashboard by ICA Minnesota, Black/African American Minnesotans are 15.1 times more likely to experience homelessness than white people and Indigenous/American Indian Minnesotans are 23.1 times more likely to experience homelessness than white residents. THP helps support Minnesota's families and individuals

[1] https://www.wilder.org/mnhomeless/results

who have experienced racism, trauma, and oppression through the homeless and housing systems by transitioning them toward housing stability.

Homeless Youth Act (HYA):

According to 2018 Minnesota Homeless Study, an estimated 13,300 youth (7,500 ages 18-24, and 5,800 age 17 or younger) who are on their own, experienced homelessness at least once over the course of a full year.[2] Wilder also estimates that on any given night in Minnesota there is an estimated 4,876 youth experiencing homelessness. This includes an estimated 1,659 minors aged 17 and under and 3,217 young adults ages 18 through 24.

A national study newly released by Chapin Hall and Howard University state that, "*Young Adults reported alarming levels of housing insecurity during the pandemic, with greatest hardships experienced by Black and Hispanic young people."*[3]

While HYA currently funds prevention activities within the context of outreach and drop-in programs, the pandemic increased the need for focusing on robust prevention efforts. One of the six recommendations that came from the Chapin Hall and Howard University report was to *prioritize youth homelessness prevention*. The report concludes, "*Without adequate investments in prevention, high rates of young adults face housing insecurity….have the potential to lead to growing levels of young adult homelessness*." Prevention efforts are the most impactful when they are available during the onset of need coupled with flexibility and people-centered supportive services. HYA funds are flexible in nature and grantees receiving these funds are youth providers who specialize in working with youth and are well positioned to support youth needing homelessness intervention services and prevention support.

The data gathered from HYA-funded providers shows that youth in HYA funded supportive housing programs had favorable outcomes in terms of housing stability as well as employment. However, the need for youth specific housing continues to grow, and an increase in HYA funding would allow for additional low barrier youth housing units, youth-centered homelessness prevention efforts, and supportive services.

Safe Harbor Shelter and Housing:

Current Safe Harbor Shelter and Housing funding does not fully meet the shelter and housing needs of youth who have experienced sexual exploitation or trafficking across our state. Several gaps exist, including but not limited to sufficient shelter and housing for male-identified youth, transgender and nonbinary youth, youth with dependent children, and culturally specific shelter and housing to meet the cultural needs of overrepresented groups, such as American Indians. Increased funds could also go to supporting greater geographic distribution and continued growth in the variety of shelter and housing program models to meet various individualized needs of this population.

During the 2022 legislative session, the Youth Services Network proposed a significant increase to Safe Harbor Shelter and Housing funding, indicating the unmet needs for additional services for this population. The legislatively mandated Safe Harbor evaluation report continues to identify gaps in our Safe Harbor network of services, with housing consistently identified as one of the greatest needs of victims of sexual exploitation. During the 2022 legislative session, both the House and Senate proposed increases to the Safe Harbor Shelter and Housing grant program.

Statutory Changes to Shelter Statutes

Revisions need to be made to the statute governing HYA Provider Repair and Improvement grants, which were approved by the legislature during the 2022 session (256K.45, subd. 7). The current statute is overly restrictive

[2] https://www.wilder.org/sites/default/files/imports/2018_HomelessnessInMinnesota_3-20.pdf
[3] https://www.chapinhall.org/wp-content/uploads/Untold-Stories-Final-Report.pdf

regarding which providers can apply for the program and the size of grant awards. Revising the statute would permit more providers to apply and give more flexibility to the types of projects funded.

Finally, the Safe Harbor Shelter and Housing grant program should be codified into statute. Currently, language for the program, which has permanent base funding, only exists in session law. Putting language into statute would codify the purpose of the program and the eligible uses of grant funding.

Proposal:

This proposal increases base funding for the Emergency Services Program, Transitional Housing Program, Homeless Youth Act, and Safe Harbor. All funding increases in this recommendation would be distributed as grants through a competitive request for proposals process.

Emergency Services Program (ESP) Increase:

This proposal includes $35 million in FY 2024-2025 and $70 million in FY 2026-2027 to increase base funding for ESP. The additional increase beginning in the FY 2026-2027 biennium represents the funding that would be needed for services to accommodate the new or expanded emergency shelters that would be created under the governor's capital request for emergency shelter facilities.

Currently, DHS funds 53 local units of government, Tribal Nations, and non-profit organizations statewide with state ESP appropriations of $13,688,000 per biennium. The average grant award is approximately $258,000. Increased funding for ESP will provide needed operational support for emergency shelters across the state that are under significant financial strain and allow providers to expand and improve services for people experiencing homelessness. In addition to supporting the operating and essential services costs of shelters, this increase will support innovative and effective approaches to unsheltered homelessness and enhanced collaboration around homeless encampments between state and local governments, Tribal Nations, and community-based organizations.

Transitional Housing Program (THP) Increase:

This proposal includes $6 million in FY 2024-2025 and $6 million in FY 2026-2027 to increase base funding for THP. Forty-three grantees were funded for the 2022-2023 biennium, with an average award of $148,000. Grantees include non-profits, local units of government, and Tribal Nations. During the 2020-2021 biennium, 2,212 individuals in 884 households received transitional housing in programs funded by THP.

This proposal will compliment, as well as increase and improve, the work that is currently being implemented by THP grantees. The increased THP funds would:

- Respond to the rate of inflation among rents and new requirements from property managers, such as paying double or triple damage deposit or having funds available to mitigate property damage.
- Allow grantees to increase wages of staff to be a competitive employer and retain employees, which would provide consistency to participants and their goals and ultimately prevent and end homelessness.
- Compliment the recent legislative change that increased THP enrollment from 24 months to 36 months.
- Expand supportive services to prevent on-going generational homelessness through increased focus on supporting Whole Family Programming. Whole Family Programming would develop services for adults and young children by increasing opportunities to address the needs of early childhood development in children and developing partnerships with existing early childhood programs located in the community.
- Increase culturally specific transitional housing units and programming/services. Culturally specific housing units and services would begin to address the racial disparities among those who are homeless, including improving access to housing and engagement in support services.

Homeless Youth Act Program (HYA) Increase:
This proposal includes $11.238 million in FY 2024-2025 and $11.238 million in FY 2026-2027 to increase base funding for HYA. For the 2022-2023 biennium, 38 Grantees were awarded HYA funds with an average award of $290,105. Grantees include non-profits, local units of government, and Tribal Nations. HYA funds are highly flexible, and this proposal would complement the work that is already taking place to support youth experiencing homelessness in the continuum of services provided.

In March 2021, DHS published a request for proposals to provide services through the Homeless Assistance Grants, which included funding for HYA. As a result, DHS received 68 applications from non-profits, local units of government, and Tribal Nations from around the State. There was over $30 million in financial requests for HYA funds, and a total of $11.024 million was distributed. This highlights a gap of over $19 million in funding, based on applications received for the 2022-2023 biennium.

Considering this gap, the proposed HYA increase would enhance the support provided to youth and young adults in the following ways:

- Provide low barrier and flexible prevention support for youth and youth households needing assistance.
- Support the youth provider community in increasing wages for youth workers to livable wages so youth workers receive adequate compensation for the important work that they do.

Safe Harbor Shelter and Housing Increase
This proposal includes $2.5 million in FY 2024-2025 and $2.5 million in FY 2026-2027 to increase base funding for Safe Harbor Shelter and Housing to fill in services gaps.

The Safe Harbor Shelter and Housing grant is an existing grant program that funds the activities of shelter, housing, and outreach services specially designed to reach and serve the population of sexually exploited youth. For the 2022-2023 biennium, 17 grantees were awarded funds with an average award of $417,650/biennium. The increase of $2.5 million is estimated to support five additional grantees with an average grant size of $500,000/biennium. The proposed increase would complement work that is already taking place to support youth experiencing sexual exploitation in their shelter, housing, and outreach needs. Goals of the increased funding include but are not limited to reaching new geographic areas as well as enhancing services to underserved populations including male victims of sexual exploitation, transgender and non-binary youth, youth with dependent children, and specific cultural groups such as American Indians.

Updates to Shelter Statutes
This recommendation amends the HYA statute to provide additional flexibility to the provider repair and improvement grant program, which the legislature approved during the 2022 session (256K.45, subd. 7). The changes will allow providers to receive a grant of up to $500,000 (rather than the current $200,000 limit), permit grantees to receive grants for two consecutive years, and ensure that providers do not currently need to be HYA grantees to receive a grant under the provider repair and improvement program.

This recommendation also codifies the Safe Harbor Shelter and Housing program into state statute. Currently, the program only exists in session law. The new statute, along with an accompanying change to the Minnesota Department of Health (MDH) Safe Harbor statute, was developed in collaboration with MDH staff.

Staff for DHS
This proposal includes 9 FTEs at DHS to administer the additional grants, manage contracts, ensure fiscal oversight, and provide technical assistance to grantees. Investments of this size require sufficient administrative resources to ensure that public dollars are managed efficiently, effectively, and with the oversight needed to maintain program integrity.

Impact on Children and Families:

While there is a growing awareness of family homelessness in Minnesota, most people still imagine emergency shelters as places where single adults escape from the cold. Despite this, children and youth continue to make up over a third of the homeless population in the state, making it essential that we invest in providing the most supportive, trauma-informed shelter possible while staff work to connect families with permanent housing.

Family shelters strive to provide as much stability and whole family services as staffing and funding allow, including social and emotional education, enrichment activities, care coordination, and connection with early childhood and other educational supports. When combined with employment and housing search, these efforts can have a positive impact on a family's trajectory as they regain housing stability, but they require significant investments of staff time and low family to staff ratios.

Both HYA and THP target support for families, children, and youth needing shelter and transitional housing. ESP funds can be used to support emergency shelters for families experiencing homelessness.

Equity and Inclusion:

Homelessness results from the intersectionality of multiple, systemic shortcomings marginalizing subsets of the population. Socioeconomic disparities and discrimination based on racial and ethnic identity, sexual orientation and/or gender identity, and ability status impact the composition of the state's homeless population. The impact of disparate treatment and access to opportunities manifests in many ways—one being the experience of homelessness. Indigenous communities and people of color remain vastly over-represented among those experiencing homelessness. Most people experiencing homelessness (62 percent) statewide in 2020 identified as Black, Indigenous, or people of color. Systematic racist policies and practices created and continue to fuel the inequities in those who experience homelessness. The transformational and targeted investments in this proposal will cement the state's commitment to housing, racial, and health justice for people experiencing homelessness.

As detailed in the most recent Wilder Research report, racial and ethnic disparities remain persistent across Minnesota—most notably among the African American and American Indian populations. African Americans make up 37% of homeless adults, despite being only 6% of the overall state population. American Indians make up 12% of homeless adults, despite being only 1% of the statewide population. Statewide statistics also highlight the representation of individuals identifying as LGTBQ+ among those experiencing homelessness. Indeed, 11% of homeless adults and 22% of young adults (age 18-24) self-identified as LGTBQ. Finally, while older adults (age 55+) constitute the smallest age cohort of those experiencing homelessness (10%), data suggest that homelessness among older adults is on the rise; homelessness among this age group increased 25% between 2015 and 2018 – a larger increase than any other age cohort. In addition, people of color, Native Americans, people with disabilities, and the LGBTQ+ populations are all over-represented in those who experience sexual exploitation.

Having communities and dedicated staff engaging with people where they're at – in the field – on a person-to-person level is key to addressing the racial and ethnic disparities in the state's homeless population.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Tribal Nations are eligible entities to apply for all funding included in this proposal. This proposal will only require additional work to Tribal Nations who apply and are funded through the request for proposals. The THP funding increase specifically targets culturally specific organizations and programs, which includes Tribal Nations and non-profit organizations that serve the Native American population.

Currently, the Safe Harbor Shelter and Housing Program does not fund any American Indian Tribes, but funding Tribes is allowable with these grant funds and in a past funding cycle the Leech Lake Tribe was funded with this grant to go through a planning process with the goal of developing shelter or housing services for sexually exploited youth. DHS has a goal of funding more services specific to the American Indian population with an increase in grant funds.

Impacts to Counties:
Counties are eligible entities to apply for all funding included in this proposal. This proposal will only require additional work to counties who apply and are funded through the request for proposals. Geographic distribution of funding is a strong consideration in allocating these funds in order to distribute impact statewide.

IT Costs:
Not applicable.

Results:
Emergency Services Program (ESP)
ESP data is collected from grantees through grantee reports and the Homlessness Management Information System (HMIS). 53 entities (non-profit organizations, local units of government, and Tribal governments) received ESP grants for the SFY22-23 biennium, with an average grant size of $129,000/year. Data below is from ESP-funded emergency overnight shelter, day shelter, and outreach programs from the period of July 1, 2021-June 30, 2022. Data was gathered through HMIS and supplemental grantee reports:

- Nearly 2,000 individuals were served in outreach programs.
- Over 7,700 individuals were served in emergency overnight and day shelters.
    - 247 (5%) of head of households served were veterans.
    - 3,500 (68%) reported a disability of long duration.
- Of the 1700 individuals for whom exit information was captured, 617 people exited into permanent housing. This includes:
    - 474 individuals qualifying as chronically or long-term homeless.
    - 314 victims of domestic violence.
- 42% of shelter guests in the state of Minnesota stayed at an ESP-funded overnight emergency shelter.

With additional state investment in ESP, new shelter beds will be created, the safety of existing shelters will be improved, and enhanced services and staffing levels will result in improved housing outcomes for people entering and exiting shelters.

Transitional Housing Program (THP)
Most grantees are required to submit a HMIS report that measure a grantee's performance. The report is the MN Core Homeless Programs report. The MN Core Homeless report provides demographics, outcome summaries, and income details on those served by THP.

The data below represents participants served by 47 THP Grantees during the SFY2020-2021 from July 1, 2019 to June 30, 2021:

- THP serves Singles and Families; 35% of THP participants were 25 years old or older; 11% of THP participants were ages 18-24; and 53% of THP participants were under 18 years old.
- 37% of THP participants identify as 36% Black or African American, 10% American Indian, 15% Multiple Races, less than 1% Asian and Native Hawaiian or Other Pacific Islander; and 11% Hispanic/Latino.
- 54% of the Adults/Head of Households enrolled in THP report having a serious mental illness disability and 18% of the Adults/Head of Households enrolled in THP report having a substance abuse disorder.
- Among Head of Households who identify as White, 15% exited to Temporary Destinations, 77% exited to Permanent Destinations, and 8% exited to Other Destinations. Among participants who identify as Black,

American Indian, or a Person of Color, 20% exited to Temporary Destinations, 72% exited to Permanent Destinations, and 7% exited to Other Destinations.

Based on the data above, THP effectively supports single adults and families who have experienced homelessness with obtaining and maintaining housing as well as transitioning to permanent housing, which achieves the program's goal of ending and preventing homelessness. Additional investments in THP will further this goal.

Homeless Youth Act (HYA)

HYA data is collected through semi-annual and annual report submissions by grantees of Homeless Youth Act funding. Aggregated data on drop-in center and outreach program activities is collected via Excel spreadsheets, and data on housing and shelter activities is collected through reports generated from the Homeless Management Information System (HMIS). The Institute on Community Alliances (ICA) is the statewide HMIS administrator and produces the aggregate HYA reports for DHS. The HMIS reports include demographics, exits and outcomes.

Data below is from HYA funded shelter and housing programs from the period of July 1, 2019-June 30, 2021.

- 1,736 unduplicated youth heads of household were served in housing.
- 1,136 unduplicated youth were served in shelter.
- 536 youth served in shelter were connected to education-related support services, and 573 connected to employment-related support services.
- 610 youth served in shelter were assisted in connecting and building a relationship with a family member or other positive, supportive adult.
- 1,351 youth served in youth supportive housing programs were connected to education-related support services and 1,595 connected with employment-related support services.
- 815 youth served in youth supportive housing programs were assisted in connecting and building a relationship with a family member or other positive, supportive adult.
- 14,608 youth were served with drop-in and outreach activities
- 9,743 youth were served in drop-in centers
- 6,679 youth were served with outreach activities

From the data above, it is evident that HYA funding supports youth experiencing homeless in meaningful ways through a continuum of services that are holistic and youth centered. Increased funding for HYA will allow providers to enhance prevention support for youth and youth households needing assistance, further enhancing the low barrier and flexible continuum of services provided to youth throughout the state.

Safe Harbor Shelter and Housing (SH)

Safe Harbor Shelter and Housing data is collected through grantees entering data on a quarterly basis through the REDCap database system administered out of the department of Health. Implementation and use of the REDCap system is new to the Safe Harbor network, and previously the Apricot data system was used. Grantees report data on individuals served by their program, number of services provided, groups provided, trainings staff attended, as well as answering narrative questions regarding program successes and challenges. Since use of the REDCap database is new and some grantees are still being oriented to using the system, not all data is available at this time. We were able to pull the number of youth served under the Safe Harbor Shelter and Housing grant from July 1, 2021-June 30, 2022, which was 200 unduplicated youth.

Safe Harbor system and program performance is also measured through a biannual evaluation report mandated by the legislature.[4] The next Safe Harbor evaluation report is in the final review stages and will be publically available soon.

[4] https://www.wilder.org/wilder-research/research-library/evaluation-safe-harbor-initiative-minnesota-phase-3-evaluation

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			25,778	30,920	56,698	45,920	45,920	91,840
HCAF					-			-
Federal TANF					-			-
Other Fund					-			-
Total All Funds			25,778	30,920	56,698	45,920	45,920	91,840
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
General Fund	47	Emergency Services Program	15,000	20,000	35,000	35,000	35,000	70,000
General Fund	47	Transitional Housing Program	3,000	3,000	6,000	3,000	3,000	6,000
General Fund	47	Homeless Youth Act	5,619	5,619	11,238	5,619	5,619	11,238
General Fund	47	Safe Harbor Shelter and Housing	1,250	1,250	2,500	1,250	1,250	2,500
General Fund	12	Children and Family Services Admin (9)	1,204	1,393	2,597	1,393	1,393	2,786
General Fund	11	FOD (1 FTE)	133	153	286	153	153	306
General Fund	REV1	Admin FFP @ 32%	(428)	(495)	(923)	(495)	(495)	(990)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
General Fund	11	Financial Operations	1	1	1	1	1	1
General Fund	12	Children and Family Services Admin (6)	9	9	9	9	9	9

Statutory Change(s)

Minnesota Statute, 145.4716
Minnesota Statute, 256K.45

Change Item Title: Direct Care and Treatment as Separate Agency

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	4,064	3,768	3,768	3,768
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	4,064	3,768	3,768	3,768
FTEs	**10.0**	**10.0**	**10.0**	**10.0**

Recommendation:
The Governor recommends separating Direct Care and Treatment (DCT) from the Department of Human Services (DHS) by establishing DCT as a stand-alone agency.

Rationale/Background:
The Department of Human Services is one of the state's largest agencies, with 7,000 employees and an all-funds budget of over $22 billion annually. DHS is charged with overseeing dozens of complex programs administered by counties and tribes and often delivered by private providers. These services touch the lives of more than 1.7 million Minnesotans, including seniors, people with disabilities, children and people experiencing mental illness and substance use disorder.

DHS also runs DCT, which is a large, highly specialized behavioral health care system that provides care to about 12,000 people a year. Most of the people served by DCT are civilly committed and have complex mental illnesses and behavior disorders. They are individuals who private providers cannot or will not serve. DCT serves a unique role in Minnesota's behavioral health treatment continuum, providing the most specialized services to those with the most complex needs.

DHS and DCT have different missions, goals, leadership and operational needs, regulatory requirements, workplaces and environments, budgetary priorities, and areas of expertise. DHS's capacity to lead and oversee the state's human services system is impacted by the responsibility to manage this large, specialized health care system. Likewise, DCT would be best positioned to operate more like other large health systems if it were established as a separate agency.

Because the nature of the work performed by DHS and DCT is so different, state lawmakers, mental health advocacy organizations and other key stakeholders have long recognized that both entities would benefit from separation. For at least a decade – and likely longer – there have been ongoing internal and external discussions about whether DCT is appropriately placed within DHS, and whether DCT should be separated.

In 2013, the Office of the Legislative Auditor found that DCT's mission was not clear in state law, that DHS's governance structure for DCT was confusing, and that DHS's oversight was insufficient at times. That same year, an analysis by Minnesota Management and Budget's Management Analysis Division (MAD) recommended

transitioning DCT from DHS and establishing it as its own service-specific state agency. In 2016, state lawmakers offered four bills that would have separated some portion of DCT from DHS. During the 2019 and 2021 legislative sessions, lawmakers offered various proposals for establishing DCT as a standalone agency.

Separating the entities would free DHS leadership to focus on policy, implementation and oversight of services that align more closely with its mission and where it has the most impact. This focus is critical for services that impact more than a quarter of Minnesotans, including child-care, services for at-risk children, people with disabilities, seniors and vulnerable adults, health care, and managing large and critically important federal programs like Medicaid. It would also reduce managerial complexity in a state agency that challenges even the most experienced leadership teams. The change also would free DCT from some of the constraints of operating within a larger agency and give it more autonomy to function more like other comparable health care systems.

In addition, the change would eliminate what many agree is an inherent conflict of interest. As currently structured, DHS regulates and pays treatment facilities that it operates. DCT operates a number of programs that are licensed by DHS and receive Medicaid payment from DHS. While DHS has taken many steps to ensure the separation and integrity of the regulator, payer and provider roles, legitimate questions and concerns remain about the appropriateness of having these overlapping responsibilities housed in the same agency.

Proposal:

The new Department of Direct Care and Treatment would be recognized as the state's premiere behavioral health care system, focused solely on serving civilly committed individuals with highly complex conditions that other systems cannot or will not serve.

This proposal is an extension of the strategic planning that DCT has engaged in each year since 2016. The transition would not affect DCT leadership or day-to-day operations at DCT facilities. DCT would continue to provide the same excellent care to 12,000 patients and clients statewide and the system would continue as usual with key stakeholders, including courts, law enforcement, counties and advocates.

Formal separation of DCT from DHS would begin implementation on July 1, 2023. The new department would work with the revisor of statutes in consultation with staff from House Research, House Fiscal Analysis, Office of Senate Counsel, and Senate Research and Fiscal Analysis to prepare legislation for introduction in the subsequent legislative session to address necessary substantive statutory changes. Legal establishment of the new agency would follow passage of substantive legislative changes, and likely be effective July 1, 2024.

Separating DCT from DHS will have no impact on the vast majority of staff in either agency. Job duties will not change. However, there will be an impact on shared functions such as human resources, compliance, legal, fiscal operations, communications, contracts and procurement. Many of these functions are already effectively separate, or mostly separate. Others sit under a single management structure, but roles and funding are separate. Decisions will be made on splitting staff and finances as part of finalizing the separation, with a goal of assuring that both agencies have the resources needed to fully function as separate agencies. The other area of shared service is Information Technology and MNIT support. DHS will work in partnership with MNIT to execute needed steps to separate IT support for the two agencies.

The new department would require funding for a board of directors and additional support positions not currently part of DCT and only partially funded under overheads DCT pays to the DHS Central Office, including external relations, legal and communications staff, for instance.

Separating DCT from DHS would also require backfilling some positions within DHS Central Office that were providing support to both DHS and DCT. This includes positions within human resources, communications and the General Counsel's Office. These are not new positions.

Equity and Inclusion:

DCT operates an array of residential and treatment programs serving people with mental illness, developmental disabilities and chemical dependency. Many of the people DCT serves are also part of one or more of the following groups: BIPOC, people with disabilities, people in the LGBTQ community, and veterans. Throughout this planning process, DCT will ensure equity and inclusion are central to DCT's continued care and services.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:

From admission to discharge, counties are deeply involved with our patients and clients, and they regularly communicate, engage, and collaborate with DCT on many levels. This proposal will maintain, improve and enhance the important partnership with counties. There is no anticipated fiscal impact to counties.

Results:

- Separating DCT from DHS would allow each agency to focus clearly on their differing missions.
- The change would also allow DHS to focus on its primary role of leading and overseeing the state-supervised, county-administered human services system and free DCT to function more like other health care systems.
- The change would eliminate any perceived or actual conflicts of interest connected with being a regulator and payer of services as well as a treatment provider.
- A more compact DCT management structure would increase accountability for continuous improvement of patient care, quality, safety and facility operations.
- Creation of a separate agency would provide permanent placement, structure and governance that is not subject to organizational changes in the larger agency.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			4,064	3,768	7,832	3,768	3,768	7,536
HCAF								
Federal TANF								
Other Fund								
Total All Funds			4,064	3,768	7,832	3,768	3,768	7,536
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	65	DCT Operations	942	1,408	2,350	1,408	1,408	2,816
GF	65	DCT Operations (MNIT Expense)	2,442	1,680	4,122	1,680	1,680	3,360
GF	11	DHS Operations	1,000	1,000	2,000	1,000	1,000	2,000
GF	Rev1	FFP @ 32%	(320)	(320)	(640)	(320)	(320)	(640)
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	65	DCT Operations	7.0	7.0		7.0	7.0	
		MNIT	3.0	3.0		3.0	3.0	

Change Item Title: Service Delivery Transformation

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	15,518	14,058	10,730	10,730
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	15,518	14,058	10,730	10,730
FTEs Maintained/New	**28/28**	**28/28**	**28/25**	**28/25**

Recommendation:

The Governor recommends $29.6 million in FY 2024-25 and $21.5 million in FY 2026-27 to transform the human service delivery system to serve clients better by evolving the way our programs, services and technology come together and are funded so that people who access services and the workers who assist them can more easily receive the support they want and need (person-centered human services). The goal of the service delivery transformation is to achieve an integrated, person-centered human services system that is simpler to use, easier to access, has less duplication, and is delivered with modern technology readily accessible to our residents and workers.

Service delivery transformation is multi-year effort that will:

- Advance existing efforts across our agencies to improve the way and speed of which we deliver value
- Impact our operating model as we become a product organization
- Support equity initiatives by giving a direct voice to populations about their wants and needs, including residents, providers, counties, Tribal Nations and DHS staff (authentic engagement)
- Continue our re-orientation to outcomes-driven measurement
- Result in a positive realignment of our organizational culture to support the new way of working

This proposal focuses on funding for initial efforts of the service delivery transformation that will:

- Provide value to our clients and county and tribal nation workers through product teams working together to deliver value and reduce the timelines for clients to for apply and receive services
- Mature our enterprise architecture in order to support product operation model
- Enhance our data management and analytics infrastructure to support integrated service delivery transformation and enable advanced analytics to understand and measure outcomes
- Bring in expertise to support the adoption and maturation of Agile frameworks and manage change across the enterprise
- Adjust our approach to sourcing and managing of our services
- Strategically invest to stabilize critical IT systems we have today

Rationale/Background:

Public and private sector organizations of all sizes face a growing challenge of delivering technology solutions much more quickly, effectively, and with a greater focus on customer needs. The state of Minnesota also faces that challenge. More than one and a half million Minnesotans participate in human service programs and depend on complex technology systems that are more than 20 years old and use suboptimal IT delivery methods to

connect them to the services they need. Over 30,000 county, tribal nation, and state staff and 200,000 providers use these systems to deliver services. Today, more than ever, there is a demand for digital and efficient delivery of services, and this proposal will improve service delivery for clients, counties, Tribes and providers.

During the 2019 legislative session, DHS received one-time funding to support the agency in establishing foundational efforts that supported the redesign of the human services delivery system. These activities created frameworks and the foundation blocks that this proposal seeks to build upon including:

- Change management
- Community and stakeholder engagement
- Establishment of architecture and standards for business, data, technology and security
- Business readiness and program simplification activities related to the service delivery transformation
- Evaluation and continuous improvement of our decision making structure
- Development of evaluation, performance and outcomes measurement and data analytics
- Development of a long-term roadmap and funding strategy
- Identifying and defining baseline technology needs

As part of the business readiness efforts above, DHS engaged Gartner in 2020-21 to evaluate our current state and provide recommendations to DHS and MNIT on a strategy for achieving our vision for "integrated service delivery" to make human services simpler and to create a better experience for the communities we serve. Gartner recommended we adopt an Agile software development approach that provides clients, staff and community partners with incremental valuable functionality, while enabling the enterprise to learn from each iteration and improve regularly along the way. Gartner's recommendation aligns with the State of Minnesota's Blue Ribbon Council on Information Technology report, as well as the already-in-progress human services Project to Product (P2P) transformation supported by Turnberry Solutions, a national provider of business, digital and talent transformation. These two initiatives are coordinating with MNIT's Office of Transformation and Strategy Delivery and with the Technology Advisory Committee to create a framework for similar transformation efforts statewide.

Proposal:

This proposal puts our prior theoretical groundwork into actual practice by incorporating the foundational building blocks needed to develop and mature product infrastructure for service delivery transformation both from a business transformation perspective and from a digital transformation perspective. The foundational building blocks include enterprise architecture and data management, user experience design, community and stakeholder engagement, performance evaluation, data analytics and change management. It also supports the implementation of baseline technology that has been identified as necessary to meet our transformation effort. Beyond our previous work, this proposal advances more current efforts to improve the way and speed by which we delivery value using a product mind-set and methodology.

There are five key initiatives included in this proposal:

<u>Expand the MNbenefits application</u>

A key aspect of the service delivery transformation is having dedicated teams working on business transformation and system modernization efforts in an agile way, as demonstrated in the Code for America partnership to develop the MNbenefits application. MNbenefits is an accessible, easy-to-use online application for nine safety-net benefit programs that clients can complete in less than 12 minutes compared to more than an hour clients spent completing the Comprehensive Application Form previously. This new application is a step forward toward Integrated Service Delivery and represents human-centered design and service delivery transformation approaches. This proposal includes funding to continue the approach used to develop MNbenefits by expanding the application and streamlining the application process to reduce the processing time.

Continue to deliver value faster

In order to gain more experience and expand the adoption of Agile, this proposal includes funding for two additional product teams that will help us continue to build out the vision of person-centered integrated services. These product teams will deliver value with short to intermediate-term enhancements that improve client communications and the worker experience. These two product teams along with MNbenefits will support progress on client-centered outcomes for our Integrated Service Delivery Product Line:

- People have easy, equitable, and uninterrupted access to benefits that holistically meet their self-determined social needs according to their personal preferences and goals.
- State, county, and Tribal Nations staff have access to simplified and integrated tools and supports they need to best serve individuals and families.

Implement foundational frameworks

In addition to the adoption of an Agile methodology, the success of this proposal depends on continuing to implement and mature the foundational frameworks we have developed.

- Enterprise architecture to guide and provide organizational structure for product development and to ensure products align to the overall vision of integrated services.
- Change management resources and tools to guide the agency through a successful transformation that will lead to person-centered, equitable decision-making, and desired agency outcomes.
- Community and stakeholder engagement to support equity initiatives by giving a direct voice to populations about their wants and needs, including residents, providers, counties, Tribal Nations and DHS staff (authentic engagement).
- Evaluation and performance measurement resources to measure the outcomes and benefits that will be delivered to achieve a more efficient and effective experience for our clients, counties, Tribal Nations, providers and ourselves.
- Management of DHS enterprise applications, systems and processes that are used throughout the agency and will be necessary to support service delivery transformation, such as, Microsoft 365 tools, Email Management initiatives, Collaboration Software Tools, Shared Master Index (SMI), Data Warehouse (DW) and FileNet.

Enhance data management and data analytics infrastructure

Any digital transformation is dependent on the reliable access and quality of data. This proposal will enhance our data management and data analytics infrastructure to support integrated service delivery transformation. Funding will support the implementation of an enterprise data management strategy, standards and policies that form the foundation for data transformation within the agency. It will also enable advanced analytics to understand and measure the impacts and outcomes of statewide programs on recipients, to detect patterns of fraud, waste, and abuse in these programs, and publish data in curated dashboards with built-in analytics to facilitate data driven decision making, improve our coordination with county, Tribal, provider, and agency partners, measure program outcomes and increase transparency with stakeholders and the public, and provide public data in a more accessible way for research partners.

Maintain critical IT systems

This proposal will provide funding to maintain some existing systems while larger transformation efforts are taking place. It will allow us to address security vulnerabilities that are being found and exploited each day.

Impact on Children and Families:

The work supported by this funding will have a positive impact on children and families. It supports Minnesota's goals for "integrated service delivery" that will make human services programs more streamlined, simpler and a better experience for the communities we serve.

Equity and Inclusion:

All groups of people will be positively impacted by service delivery transformation since Human Centered Design principles and a focus on building inclusion drives this work. Additionally, there is strong potential to realize many of the outcomes of DEI initiatives through the operationalization of product/Agile ways of working. For example, one of the Agile values prioritizes "individuals and interactions over processes and tools", which means product teams need to understand the lived experiences of the people who use the products they support. They empathetically develop that understanding by interacting directly with customers and end users to guide and prioritize the development of their work. Agility does not guarantee equity, but opportunities exist in this way of working that can be achieved with intentionality.

Minnesota's goals for service delivery transformation are to make human services simpler and create a better experience for the communities we serve. Some of the key guiding principles include racially and culturally appropriate efforts to support an equitable service delivery system, utilizing a person-centered framework, using the "social determinants of health" to identify root causes of an individual or family's need for services, and using a multi-generational approach which takes into account the needs of the whole family. In developing the Integrated Services Business Model (ISBM), stakeholder feedback was gathered from representatives of all disadvantaged groups of people. The goal for the service delivery transformation effort and the development of an integrated service delivery system is to reduce or eliminate disparities for all groups.

Measurement and dissemination of data about the department's programs and their outcomes would advance equity and improve transparency and accountability.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Impacts to Counties:

The service delivery transformation effort is a collaborative approach that actively includes counties as a key partner. Minnesota's goals for service delivery transformation are to make human services simpler and create a better experience for the communities we serve, including the role of county workers.

This proposal also creates the analytics infrastructure necessary to share important data with our county partners.

IT Costs

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll	$10,681	$10,147	$8,734	$8,734	$8,734	$8,734
Professional/Technical Contracts	$3,100	$2,300	$500	$500	$500	$500
Infrastructure						
Hardware	$954	$954	$838	$838	$838	$838
Software	$250	$125	$125	$125	$125	$125
Training	$300	$300	$300	$300	$300	$300
Enterprise Services						

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Staff costs (MNIT or agency)	$233	$232	$233	$233	$233	$233
Total	**$15,518**	**$14,058**	**$10,730**	**$10,730**	**$10,730**	**$10,730**
MNIT FTEs	28	28	19	19	19	19
Agency FTEs (New/existing)	28/28	28/28	28/25	28/25	28/25	28/25

Results:

- A formalized, funded infrastructure for the agency with dedicated resources to effectively manage enterprise technologies and information and a product-centric way of managing transformation initiatives
- A shared vision of what service delivery transformation means and the necessary resources needed to realize that vision
- Dedicated resources to lead and support enterprise-wide adoption of agile frameworks and practices
- A data-focused interoperability framework
- A deliverable based sourcing/vendor management model
- Improved and streamlined worker processes and satisfaction for handling applications
- Improvements to the MNbenefits application to interface with MAXIS which will result in less worker intervention in the application process
- More benefits available through the MNbenefits application
- Improved communications to clients that are timely and easily understood.

The agency will know if these outcomes are successful if the following are in place:

- Clients receive more timely information
- Clients receive information in plain language and in multiple languages
- An enterprise infrastructure is in place and its roles and responsibilities are shared and understood by its stakeholders
- The human services enterprise workers know and understand what service delivery transformation means and can see themselves in that vision
- Mature enterprise information and technology architecture domains
- Enterprise adoption of person-centered product, Agile frameworks and practices
- Improved data management, access, data sharing and analytics across the human services enterprise
- Business outcomes are realized and vendor accountability practices are being used
- Worker processes result in decreased time from initial application to approval of benefits
- Workers experience reduced data entry in the application process

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			15,518	14,058	29,576	10,730	10,730	21,460
HCAF								
Federal TANF								
Other Fund								
Total All Funds			15,518	14,058	29,576	10,730	10,730	21,460
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	DHS IT OPS Administration	10,627	10,046	20,673	8,632	8,632	17,264
GF	13	DHS IT HCA Administration	287	334	621	334	334	668
GF	11	IT Hardware/Software	1,204	1,078	2,282	964	964	1,928
GF	11	Professional Contracts	3,100	2,300	5,400	500	500	1,000
GF	11	IT Training	300	300	600	300	300	600
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	Operations Administration – 53 FTEs	53	53		50	50	
GF	13	Health Care Administration – 3 FTEs	3	3		3	3	

Change Item Title: Permanent Reprioritization of the Child Care Assistance Program Basic Sliding Fee

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Federal Funds				
Expenditures	0	7,824	8,406	8,960
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	7,824	8,406	8,960
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends investing $7.8 million in FY2024-2025 and $17.4 million from the federal Child Care Development Fund in the FY 2026-2027 biennium for changes to the Child Care Assistance Program (CCAP) to permanently reprioritize Basic Sliding Fee (BSF) child care.

Basic Sliding Fee child care was temporarily reprioritized during the 2021 Legislative Session and is currently set to revert to the previous prioritization order after May 31, 2024. This proposal would make the temporary reprioritization changes permanent.

Rationale/Background:

Basic Sliding Fee (BSF) child care helps families pay for child care while they look for work, go to work, or attend training to prepare for work. This program helps make quality child care affordable for families with lower incomes and can boost the workforce participation rate by making child care more affordable and accessible. Counties and two Tribal Nations receive a capped allotment of money to use each year and BSF child care is provided on a first come-first served basis until funds are allocated fully. A waiting list is established in those counties or Tribal programs where the demand for BSF exceeds the amount of funding available.

The MFIP portion of CCAP is forecasted. Families who have participated in MFIP or DWP in the past year are served through Transition Year (TY) child care for the first year and then through Transition Year Extension (TYE) child care until BSF funds are available. These families do not have to wait to receive child care assistance.

State statute requires counties to prioritize BSF funding for families exiting MFIP.[1] However, these families already receive child care through TY and TYE child care (part of the forecasted MFIP child care), which does not use limited BSF funds. In 2021, a temporary reprioritization of the BSF wait list was enacted.[2] The temporary reprioritization allows families to continue receiving TY or TYE child care so other families on the wait list can access BSF. This change has allowed scarce BSF funds to be spent on families who are not eligible for TY or TYE, permitting more children to receive care and more families to receive child care assistance. Permanent reprioritization of the BSF wait list will increase and extend these good results.

[1] Sec. 119B.03 MN Statutes

[2] Temporary reprioritization is effective from July 1, 2021 to May 31, 2024

This proposal was identified as a high priority by the Minnesota Association of County Social Service Administrators (MACSSA). This has been a priority for MACSSA since at least 2019.

Proposal:

This proposal would permanently modify the CCAP BSF waiting list. This permanently moves families eligible for TYE to the lowest priority for BSF. In counties with waiting lists, this would mean the county could serve families who are not currently receiving assistance before serving families on TYE child care. Families on TYE child care currently receive assistance and will continue to receive assistance under this proposal. This will likely result in families staying on TYE child care longer since families in the other four waiting list priorities will be served before them.

This proposal funds the cost for families staying on TYE child care longer under permanent reprioritization. These costs are for the MFIP child care program since TYE child care is funded through the forecasted MFIP child care program.

This proposal compliments the department's efforts to ensure Minnesota's children and families have access to quality, reliable, and affordable child care. This proposal would impact MFIP child care because it would increase the amount of time some families will stay on TYE child care. There is not an impact to the MFIP cash program.

The effective date is June 1, 2023. Because this would not change administration of waiting lists until May 31, 2024, there is not an impact to the budget until State Fiscal Year 2025.

Impact on Children and Families:

CCAP helps families pay for child care so that parents can work or go to school. It helps ensure that families can access affordable child care and children are supported to achieve their highest potential in child care settings that best meet family needs and preferences. CCAP typically serves approximately 15,000 families and 30,000 children each month. An average of 2,650 providers receive CCAP payments each month.

This proposal builds on recommendations from local CCAP administrators and advocates for children and families to help increase access to BSF child care, expands access to affordable and quality child care and early education, and helps Minnesota's children and families access CCAP more quickly.

Equity and Inclusion:

This proposal will permanently reprioritize Basic Sliding Fee waitlist to maximize the number of children who can receive CCAP. As of September 2022, there were 1,165 families on waiting lists statewide. In the last ten years the number of families on the waiting list has ranged from 372 (April 2022) to 8,300 (January 2014).

In State Fiscal Year 2021, 61% of all children receiving CCAP through BSF child care were children of color, specifically Black or African-American, Asian/Pacific Islander, Hispanic/Latino, multiple races, and American Indian children. Of all children served, 46% are Black or African-American. Accordingly, increasing access to BSF child care will more greatly impact and benefit Black and African-American children and families and help eligible families access CCAP more quickly.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

The department engaged with Tribal Nation agencies through MNTRECC on this proposal.

Impacts to Counties:

This proposal could impact counties financially. Funds from this proposal will serve more families through BSF and increase caseloads for county workers. Counties have indicated they can manage those changes. Permanently reprioritizing the Basic Sliding Fee waiting list will make waitlist management easier for local agencies because they will not have to try to account for families in their MFIP transition year when managing other families on the BSF waiting list.

Counties had brought forward this proposal in previous sessions and have identified reprioritization as a major priority. CCAP has discussed this proposal with counties and they continue to support reprioritization of the BSF waiting list.

IT Costs:

This proposal has no systems costs or changes as it does not require any changes to MEC.

Results:

This proposal permanently modifies the existing BSF child care waiting list priorities. The results of this proposal would be measured in the number of families receiving CCAP through BSF child care and the number of families who are on the statewide and county waiting lists.

Since reprioritizing the BSF waiting list in the 2021 legislative session, program waiting lists have decreased significantly. Prior to reprioritization, in February 2020, there were 2,265 families on the BSF waiting list. As of July 2022, there were 766 families on the waiting list statewide.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			-	-	-	-	-	-
HCAF					-			-
Federal TANF					-			-
Child Care Development Fund			-	7,824	7,824	8,406	8,960	17,366
Total All Funds			-	7,824	7,824	8,406	8,960	17,366
Fund	**BACT#**	**Description**	**FY24**	**FY25**	**FY24-25**	**FY26**	**FY27**	**FY26-27**
3000	22	MFIPChildCare	-	7,824	7,824	8,406	8,960	17,366
		RequestedFTE's						
Fund	**BACT#**	**Description**	**FY24**	**FY25**	**FY24-25**	**FY26**	**FY27**	**FY26-27**

Statutory Change(s):

Minn. Stat. § 119B.03

Change Item Title: Child Care Assistance Program Basic Sliding Fee Investments

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	15,000	15,000	15,000	15,000
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	15,000	15,000	15,000	15,000
FTEs	**0**	**0**	**0**	**0**

Recommendation:
The Governor recommends investing $15 million from the general fund annually to support the Child Care Assistance Program (CCAP) Basic Sliding Fee (BSF). These additional funds ongoing will help local agencies to increase the number of families served by CCAP and reduce the existing BSF waiting list.

Rationale/Background:
This proposal impacts children and families who are eligible to receive child care assistance but do not or cannot participate in the Minnesota Family Investment Program (MFIP). Families who have not participated in MFIP or the Diversionary Work Program (DWP) in the past year but meet income limits and other eligibility criteria may qualify for Basic Sliding Fee (BSF) child care. The BSF portion of the CCAP program is a capped allocation, so in some counties and tribal agencies, there is a waiting list for families to access BSF child care. The MFIP child care program is forecasted; families who currently participate or have participated in MFIP or DWP in the past year do not have to wait to receive child care assistance.

In previous years, BSF has received one time infusions of funds in part through COVID-19 relief dollars from the federal government. These dollars helped increase the number of children and families who can access CCAP, but because the funds have been one time, local agencies been limited in the number of families they can serve from their waiting lists.

Proposal:
This proposal increases the base amount of funding available for BSF statewide by $15 million dollars each year.

Impact on Children and Families:
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 typically serves approximately 15,000 families and 30,000 children each month. An average of 2,650 providers receive CCAP payments each month.

This proposal will increase annual investments to BSF by $15 million each year to help increase the availability of CCAP for children and families statewide. This investment could serve approximately 560 additional families (1,120 additional children) in the first year and up to 500 (1,000 children) in the following years. Over the course of FY 2024-2027, this proposal could serve approximately 2,000 additional families (4,000 children). As of November 2022, there were 2,238 families on waiting lists statewide.

Equity and Inclusion:

In State Fiscal Year 2021, 61% of all children receiving CCAP through BSF child care were children of color, specifically African-American, Asian/Pacific Islander, Hispanic/Latino, multiple races, and American Indian children. Of all children served, 46% are African-American. Accordingly, increasing access to Basic Sliding Fee child care will more greatly impact and benefit African-American children and families.

Public Engagement:

The department has engaged with MACSSA, tribal agencies, and organizations representing families and providers during the previous legislative sessions on how to best support providers and families, including addressing the waiting list for Basic Sliding Fee CCAP staff discussed ideas with the following:

- CCAP Program Integrity Work Group, June 30, 2022
- Minnesota Department of Education, July 7, 2022
- Minnesota Tribal Resources for Early Childhood Care (MNTRECC), July 14, 2022
- Early Childhood Education Advocates, July 19, 2022
- Family Friend Neighbor (FFN) Direct Support Grantees, July 28, 2022
- Minnesota Association of County Social Service Administrators (MACSSA) Self Sufficiency Group, July 12, 2022 and August 9, 2022
- CCAP Agencies, August 9, 2022
- CCAP Provider Cohort, August 10, 2022
- First Children's Finance, August 18, 2022
- County and MACSSA – Basic Sliding Fee CCAP discussion group, August 18, 2022
- Metro CCAP Agencies, September, 2022

Impacts to Counties:

This proposal will increase the workload for county agencies administering CCAP. Although counties will have more cases to manage, counties have been supportive of establishing an ongoing investment to BSF to allow them to better manage waiting lists. Local agencies plan how they will manage waiting lists 2-3 years in advance, so ongoing funding rather than one time funding will improve their ability to manage their allocated funds.

Impacts to Tribes

This proposal will impact White Earth Nation and Red Lake Nation specifically as they administer CCAP in partnership with the state. Other tribal nations may have participants receiving CCAP, but those cases are administered through a county or local agency.

This proposal will increase the workload for White Earth Nation and Red Lake Nation and they will manage additional cases. White Earth Nation and Red Lake Nation typically do not currently have waiting lists, but this policy change could increase the number of applicants for CCAP.

Results:

This proposal will increase the number of families who are able to access CCAP without having to spend time on waiting lists. As of November 2022, there were 2,238 families on waiting lists statewide. In the last ten years, the number of families on waiting lists has ranged from 500 (August 2021) to 8,300 (January 2014). This proposal could serve approximately 560 additional families (1,120 additional children) in the first year and up to 500 (1,000 children) in the following years. Over the course of FY 2024-2027, this proposal could serve approximately 2,000 additional families (4,000 children).

IT Related Proposals:

This proposal does not require changes to the Minnesota Electronic Child Care Systems (MEC^2).

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			15,000	15,000	30,000	15,000	15,000	30,000
HCAF								
Federal TANF								
Other Fund								
Total All Funds			15,000	15,000	30,000	15,000	15,000	30,000
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	42	Basic Sliding Fee	15,000	15,000	30,000	15,000	15,000	30,000
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

There is no statute change needed, just appropriation language.

Change Item Title: Supporting the Child Care Industry and Workforce

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	170,672	174,226	176,751	177,769
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	170,672	174,226	176,751	177,769
FTEs	**24.5**	**24.5**	**24.5**	**24.5**

Recommendation:

The Governor recommends investing $344.9 million in fiscal years 2024-2025 and $354.5 million in fiscal years 2026-2027 from the general fund to address Minnesota's child care shortage and strengthen and expand the child care industry.

This investment includes:

1. Retention payments to child care programs to help ensure child care capacity is consistently available to families throughout Minnesota. These payments will include funding for child care programs to increase wages and benefits for early eductors.
2. Funding to provide ongoing training, recruitment and higher education scholarships to increase the number of qualified early educators to work in child care programs, and address the workforce shortage.
3. Grants and supports to equip providers with information and tools to start up and effectively operate child care businesses, including local technical assistance for child care providers, family child care shared services alliances, and support for provider business practices through training, consultation, and technology access.

Rationale/Background:

While access to child care is critical to Minnesota's economic growth and vitality, child care shortages persist across the state. The need for equitable, affordable and sustainable child care is essential for strong child development and economic stability of families and communities. The challenges facing the industry are tied to market failures that create tensions between affordability for families and a sustaining career path for child care providers.

The federal American Rescue Plan Act (ARPA) provided states with a unique opportunity to support the struggling child care industry. Minnesota used ARPA and other one-time federal funding to provide stabilization grants to licensed family child care providers, licensed child care centers, and certified child care centers[1] for a variety of purposes throughout the pandemic, including support for operational expenses, employee wages, business consultation, and facility revitalization. Stabilization grants end June 30, 2023 and federal funds for the program must be expended by September 30, 2023. These efforts stemmed the loss of child care access during the

[1] Certified child care centers are license-exempt child care centers that participate in the Child Care Assistance Program. These centers are typically located in public school-based settings, and serve either preschool-age or school-age children.

pandemic and are starting to show impacts; however, too many Minnesota families still have very limited or no access to child care.

While all of Minnesota's businesses are struggling with workforce shortages and pandemic recovery, child care programs are uniquely burdened. Many are small businesses that operate on thin margins, with unstable business models. Provider revenue is currently insufficient to keep many programs in business and to provide competitive wages and benefits to their employees.

Shortages in child care providers and staff has a cascading effect on broader workforce participation. This proposal takes targeted steps, consistent with recommendations in the Minnesota Business Vitality Child Care Sprint Report[2] and the Governor's Economic Expansion Roadmap[3], to strengthen the child care industry and in turn our state's economy.

Through engagement with child care providers, the Minnesota Department of Human Services (department) continues to hear concerns about the child care shortage, the child care worker crisis, and the need for continued financial supports and other resources that can help existing child care providers stay in business and expand, or new providers to join the industry. Strengthening this sector and addressing its market failures requires a transformation of child care financing.

The initiatives in this proposal will allow the department to robustly strengthen and expand the child care industry by providing much needed financial and business supports for providers. Doing so will help ensure availability of child care for Minnesota's workforce. These strategies will also support child care programs to develop stronger business practices, use technology, establish new or expand existing child care programs to serve more children, and continue to support training and professional development to strengthen Minnesota's child care workforce.

Proposal:

This proposal provides permanent funding to strengthen the child care sector through a Child Care Retention Program and other supports to build and maintain the supply of child care in Minnesota.

Transition Child Care Stabilization Grants

This proposal provides $46.55 million in fiscal year 2024 to continue Child Care Stabilization Grants[4] from July 1 through September 30, 2023. The extension of this existing program will allow three months of transition grants to ensure continued financial support for child care programs while the department prepares for the launch of the new child care retention program established by this proposal beginning in October 2023.

Child Care Retention Payments

This proposal establishes a new state-funded Child Care Retention Program. The program will provide payments to eligible child care providers to provide increases in compensation and benefits for early educators working in eligible programs, moving this workforce closer to a livable wage.

Child care centers will be required to use these payments only for increased compensation and benefits. Family child care providers will be provided flexibility in use of these funds, recognizing their unique business models. While some family child care providers have paid staff, and some have incorporated their businesses, most do not have paid staff and are sole proprietors. As a result, their businesses are run very differently than child care centers. The design of this program will recognize these differences to ensure ease of participation for family child care providers.

[2] Link to Minnesota Vitality Council Child Care Business Supports Working Group: Final Report and Recommendations. April 2022.

[3] Link to Minnesota's Moment: Roadmap for Equitable Economic Expansion. June 30, 2022.

[4] Laws of Minnesota 2021, 1st Special Session, Ch. 7, Art. 14, § 21

Costs and Payment Amounts

The cost for retention payments is $120 million in fiscal year 2024, $168.704 in fiscal year 2025, $161.7 million in fiscal year 2026, and $161.715 million in fiscal year 2027 (and ongoing) to be made available beginning October 1, 2023.

All licensed and certified child care programs will be eligible to receive retention payments each month via an application process that confirms that they are open and operating and willing to meet other requirements for use of funds.

The funding amount per program will be based on a per Full-Time Equivalent (FTE) basis, with one FTE defined as 32 hours per week working directly with children, and no one individual counting as more than 2 FTEs.

Payments will be increased by 25% for child care programs that 1) serve children receiving funding from the Child Care Assistance Programs or Early Learning Scholarships, or 2) are located in Child Care Access Equity Areas. Child Care Access Equity Areas are areas of the state with low access to child care, higher poverty and unemployment rates, and lower homeownership and median household incomes. The process of establishing Child Care Access Equity Areas would use a method developed by the department. Approximately 2,800 child care programs would receive this bonus.

Numbers Served

In fiscal year 2024, it is estimated that this program will benefit:

- Over 230,000 children served in participating programs
- Approximately 1,500 licensed child care centers, 500 certified centers, and 4,700 family child care programs, and
- 35,000 early educators.

Program Requirements and Continuous Improvement

Participating programs will be required to serve a minimum of three children per family child care or center classroom, or two children for family child care providers with a Class B1 license, who serve only infants and toddlers. In order to ensure this requirement is met, participating programs will be required to regularly report on child enrollment and attendance.

Licensed and certified centers will be required to use this funding to provide or contribute to annual increases in staff compensation or benefits. A wage and benefits ladder, consistent with the compensation framework currently under development by the Great Start Task Force, will be provided as a guideline for participating programs.

Licensed family child care providers will not be required to increase compensation and benefits, but rather will be encouraged to use the wage and benefits ladder to establish compensation and benefits that provide a livable wage for themselves and any paid staff. This flexibility is necessary for licensed family child care providers because most are sole proprietor small business owners, and do not have paid employees. Those with paid employees would be required to document they have paid staff, and the hours worked each month.

The department will establish a process to evaluate and improve this new program over time, updating program requirements as appropriate and to ensure that the program is administered to achieve its intended purposes, with strong internal controls and accountability strategies for child care providers receiving these funds.

Legal Non-licensed (LNL) Providers

Legal non-licensed (LNL) providers[5] will be eligible for one-time retention payments of up to $500 for the month they begin receiving CCAP. The purpose of the one-time payment is to support LNL providers in providing child care to CCAP-eligible children and can be used for costs including, but not limited to, training and equipment. It is estimated that up to 50 LNL providers will participate per year.

Recruitment, Training and Higher Education Scholarships

This proposal will increase the number of individuals qualified to work in the child care industry in Minnesota through recruitment, training and higher education scholarships.

- $1.3 million in fiscal year 2025 and ongoing is to extend the Empower to Educate Program. This workforce development grant program was established in 2021 with $3 million in ARPA funds to recruit and provide child care training, job skills and job placement, targeted to economically disadvantaged individuals, to increase the number of people prepared to enter the early care and education workforce.[6] This program is carried out by organizations operating child care resource and referral programs under Minnesota Statutes, section 119B.19.
- $695,000 in fiscal year 2025 and ongoing is for higher education scholarships through the TEACH program.[7] This is consistent with an increased appropriation for TEACH in 2021 paid for with $2 million in ARPA funds.[8]

Supports for Expansion of Child Care Programs

This proposal will also strengthen the child care sector in Minnesota by providing funding to equip providers with information and tools to start up and effectively operate child care businesses and support the child care workforce, including through increased access to technology for child care providers, and extending existing funding for supports for new and existing child care programs. Currently, funding through ARPA pays for many of these supports, but ARPA funds will end in fiscal years 2023 and 2024; additional funds are needed to continue these programs on an ongoing basis.

Supports for child care programs will include:

- $2.920 million in fiscal year 2025 and ongoing to extend Child Care Wayfinder, the Child Care One-Stop Assistance Network. This program was established in 2021 using $3 million in ARPA funds to develop a network to support the start-up of new child care programs, and expand and sustain existing child care programs.[9] This program is carried out by organizations operating child care resource and referral programs under Minnesota Statutes, section 119B.19.
- $1.250 million in fiscal year 2024 and $1.5 million in fiscal year 2025 and ongoing for child care business training and supports under Minnesota Statutes 119B.25. This program was established in 2021 and paid for with $3 million in ARPA funds.[10]
- $500,000 in fiscal year 2024 and ongoing for Shared Services Alliances. These alliances help family child care providers achieve economies of scale and run more efficient programs, boosting provider wages, increasing enrollment, and leveraging shared support services to improve quality. This funding would follow a pilot program for Shared Services Alliances established in 2021 and paid for using $200,000 in ARPA funds.[11]

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[5] Legal Non-Licensed (LNL) providers are typically family, friends or neighbors that meet specific requirements and are registered to receive payments for care through the Child Care Assistance Program.

[6] Laws of Minnesota 2021, 1st Special Session, Ch. 7, Art. 8, § 11(c)

[7] TEACH is a scholarship program that helps early childhood and school-age educators increase their levels of education, compensation, and commitment to the field by earning college credits and degrees. Minn. Stat. § 136A.128

[8] Laws of Minnesota 2021, 1st Special Session, Ch. 7, Art. 8, § 11(c)

[9] Laws of Minnesota 2021, 1st Special Session, Ch. 7, Art. 2, §§ 79 & 84(a)

[10] Laws of Minnesota 2021, 1st Special Session, Ch. 7, Art. 8, § 11(c)

[11] Laws of Minnesota 2021, 1st Special Session, Ch. 7, Art. 14, §§ 16 & 23(i)

- $300,000 in fiscal year 2024 and ongoing for technology grants or other supports to child care providers to improve their access to computers, the Internet, and subscriptions to online child care management applications that could be used to help them improve their business practices. It will also provide funding for technical assistance around use of technology for providers.

Administrative Costs for Proposal

This proposal includes $6.951 million in fiscal year 2024 and $5.807 million in fiscal year 2025 from the general fund and ongoing for the department to administer these activities. There are 23.5 permanent FTEs included in this proposal. These FTEs would provide the support needed to administer the program, including:

- 7 FTEs in the Child Care Services Division for project management, policy development and implementation, provider communication and technical assistance, payments administration, data analysis, and supervision of staff implementing this program.
- 5 FTEs in the Office of Inspector General (OIG) Data and Analytics unit for data analysts to carry out analyses needed for program integrity purposes, and supervision of OIG Data and Analytics unit staff.
- 6 FTEs in the OIG Financial Fraud & Abuse Investigations Division (FFAID) to establish a robust and responsive unit within the Child Care Assistance Program within FFAID. Four auditor/investigator positions to audit and investigate compliance with program requirements, and one supervisor to oversee the new unit. Lastly, one staff attorney is necessary to manage an anticipated increase in appeals.
- 2 FTE for Financial Operations to oversee associated financial operations and support funding dissemination through grant contracts needed to implement the program.
- 1 FTE for Children and Families Services to provide increased financial support to child care services.

Administrative costs for this proposal also include 3.5 FTEs for the Minnesota information technology agency, MN.IT. These positions would support implementation of the payments module and ongoing support. In addition to staff FTEs, this proposal provides $3.025 million in fiscal year 2024 for payments module software, integration with child care management software systems used by child care programs, and a contracted support team to configure the payments module. Software integration costs in the following fiscal years will be $1.6 million to integrate additional child care management software systems, and for ongoing payments module consulting support, and ongoing software and associated costs.

The proposal includes $233,000 in fiscal year 2024 and $56,000 in fiscal year 2025 for contracted project management. This funding will ensure a smooth transition from the Child Care Stabilization Grants Program to the new Child Care Retention Program, and will oversee set up of the new application and data systems needed to administer the new Child Care Retention Program payments.

This proposal provides $600,000 annually starting in fiscal year 2024, to ensure that a grantee, Child Care Aware of Minnesota, has adequate staff to answer questions and provide technical assistance to child care providers when they apply for Child Care Retention Program payments.

This contract also provides $100,000 in fiscal year 2024 and $200,000 in fiscal year 2025 and on-going for a professional technical contract for evaluation, to support the department in understanding program impacts.

Impact on Children and Families:

This proposal helps address the Walz administration's One Minnesota goal of increasing the number of Minnesota families with adequate access to child care. It also builds on and complements work that began before and during the COVID-19 pandemic, including the Child Care Stabilization Grant Program, Child Care Economic Development grants provided by the Minnesota Department of Employment and Economic Development (DEED), and grants and supports provided by the Minnesota Initiative Foundations to address rural child care shortages.

The activities in this proposal will increase access for children and families to quality child care through:

- Retention payments to retain child care programs, strengthening their businesses; this will be particularly helpful to rural family child care programs, which are often the only child care option in their areas. The proposal also helps to bridge the opportunity gap for children by providing higher payment amounts to providers serving families receiving CCAP and Early Learning Scholarships, or those who are located in areas with low access to child care.
- Coaching and consultation to support the establishment of new child care programs to open and connect new providers to child care program supports.
- Strengthening child care businesses through access to technology, as well as training and consultation on business skills, use of technology, and shared services alliances.

The proposal will also support new people to join the child care workforce and stay in the workforce by providing:

- Retention payment funds to help child care programs hire and retain a qualified workforce.
- Training and supports to financially-challenged individuals to join the child care workforce.
- Higher education scholarships through the TEACH program.

Many of the ideas in this proposal originated from recommendations made by the Family Child Care Task Force in its report[12] released in January 2021. This task force included representatives from family child care, families, and other advocacy groups. Family child care providers were also engaged to provide feedback in the development of the Child Care Retention Program. Some of their feedback included information passed along from client families.

The Great Start Task Force will release its final report in February 2023. Based upon task force work to date, it is anticipated that many of the ideas in this proposal will align with their final recommendations.

Equity and Inclusion:

The Child Care Retention Program centers equity by providing 25 percent higher payment amounts to child care providers serving children receiving funding through the Child Care Assistance Program or Early Learning Scholarships program, or that are located in Child Care Access Equity Areas. Child Care Access Equity Areas are areas of the state with low access to child care, higher poverty and unemployment rates, and lower homeownership and median household incomes. The Child Care Access Equity Areas would be established by the department. In addition, we know that the majority of children receiving funding through the Child Care Assistance Program are also Black, Indigenous, and People of Color (BIPOC).

Communities in Greater Minnesota have traditionally relied upon family child care providers to serve the needs of their communities. Therefore, the steady ongoing loss of family child care providers has impacted rural communities more. While there has been an increase in the number of child care centers, these spaces are disproportionately located in the Twin Cities metro area.

The programs funded in this proposal would address racial, economic, and geographic equity. Implementation of these programs will center racial equity, with focused efforts for child care capacity-building to ensure recruitment is targeted strategically to places with higher numbers of BIPOC families to ensure the need to address lack of access to child care in these communities is addressed. The financial and other supports in this proposal should reduce the loss of family child care providers across the state, and help prospective family child care providers establish new businesses.

[12] Link to report of the Minnesota Family Child Care Task Force. Legislative Report. February 2021.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

The department met with representatives from tribes to discuss the ideas included in this proposal. Tribes were also engaged in the development of these strategies through work groups on these topics, and ongoing meetings with department staff.

Implementation of the programs in this proposal may result in a need for staff to provide support for tribally licensed programs. A grantee, Minnesota Tribal Resources for Early Child Care (MNTRECC), will receive separate Child Care Development Fund funding to help connect individuals interested in becoming licensed with staff in Child Care Aware agencies, help tribal programs access resources, and help Child Care Aware agencies serve tribal programs well.

Impacts to Counties:
Representatives from some counties were engaged in workgroups to develop the Child Care One-Stop Assistance Network and Workforce Development Grant programs, now called Child Care Wayfinder and Empower to Educate. If this proposal results in a significant increase in the number of licensed child care programs, counties may need more licensors to keep up with the need to process license applications, which includes onsite visits. The department will continue having conversations with counties about the impact of this proposal on their licensing services.

Results:
This proposal is part of a broader statewide effort to increase access to child care for families, led by the Child Care Action Team, coordinated by the Minnesota Children's Cabinet. These efforts collectively are working toward the One Minnesota Goal of increasing the number of families in Minnesota with adequate access to child care from 75% to 91%. The progress of our state toward this goal will be tracked ongoing through a collaboration between department staff and the University of Minnesota's Child Care Access project (www.childcareaccess.org).

<u>Child Care Retention Program</u>
DHS will provide financial support to the following number of child care programs:

- Approximately 1,500 licensed child care centers, 500 certified centers, and 4,700 family child care programs
- An estimated 35,000 early educators will benefit from these payments annually through increased compensation and benefits.

DHS will collect and synthesize data on how funds were used to determine impacts of the program. The department will also assess if these funds were distributed equitably by analyzing the following data:

- Program location and the percent located in Child Care Access Equity Areas
- Race and ethnicity of the center director or provider

<u>Supports that equip providers with information and tools to start up and effectively operate child care businesses and support the child care workforce</u>
The goal is to serve approximately:

- 600 child care providers per year through coordinated supports provided by Child Care Wayfinder, the One Stop Assistance Network.
- 750 early educators per year through Empower to Educate, funded with the Workforce Development Grants
- 300 family child care providers through shared services alliances

- 300 child care providers through the technology supports
- 2,400 early educators per year through child care business training and supports
- 90 early educators per year through the TEACH program

DHS will track progress using the following measures:

- Number of slots created by year
- Number of new child care programs opened, including geographical data
- Number of child care programs that closed, including for recipients and non-recipients of Child Care Retention Program payments
- Increased wages and benefits of early educators employed in child care programs receiving Child Care Retention Program payments
- Number of individuals trained and qualified to join the child care workforce
- Number early educators retained
- Job placements
- Jobs received

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			170,672	174,226	344,898	176,751	177,769	354,520
HCAF								
Federal TANF								-
Other Fund					-			-
		Total All Funds	170,672	174,226	344,898	176,751	177,769	354,520
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	43	Child Care Retention Program Payments	117,250	162,950	280,200	165,475	166,493	331,968
GF	43	Transition Grants	46,550	-	46,550	-	-	-
GF	43	Child Care One-Stop Assistance Network	-	2,920	2,920	2,920	2,920	5,840
GF	43	Workforce Development Grants	-	1,300	1,300	1,300	1,300	2,600
GF	43	Shared Services	500	500	1,000	500	500	1,000
GF	43	Technology grants	300	300	600	300	300	600
GF	43	Business training and supports	1,250	1,500	2,750	1,500	1,500	3,000
GF	43	TEACH	-	695	695	695	695	1,390
GF	12	Children and Family Services Staffing and Payments Module Infrastructure	4,730	3,670	8,400	3,670	3,670	7,340
GF	11	Office of Inspector General Admin	1,432	1,619	3,051	1,619	1,619	3,238
GF	11	MNIT support	675	391	1,066	391	391	782
GF	11	Financial Operations	255	292	547	292	292	584
GF	REV1	Admin FFP @ 32%	(2,270)	(1,911)	(4,181)	(1,911)	(1,911)	(3,822)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	12	Children and Family Services Admin	8	8	8	8	8	8
GF	11	Office of Inspector General Admin	11	11	11	11	11	11
GF	11	MNIT Admin	3.5	3.5	3.5	3.5	3.5	3.5
GF	11	Financial Operations	2	2	2	2	2	2

Statutory Change(s):

This proposal requires rider language and the addition of new sections in Chapter 119B.

Change Item Title: Supporting Working Minnesotans

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	704	1,578	12,955	16,124
Revenues	0	0	0	0
Other Funds				
Expenditures	0	1,402	16,160	20,037
Revenues	0	0	0	0
Net Fiscal Impact =	704	2,980	29,115	36,161
(Expenditures – Revenues)				

Recommendation:

The Governor recommends investments of $2.3 million from the general fund and $1.4 million from the Temporary Assistance for Needy Families (TANF) fund in FY 2024-25 and $29.1 million from the general fund and $36.2 million from the TANF fund in FY 2026-27 to make the Minnesota Family Investment Program and General Assistance more effective at supporting economic stability for low wage workers and to simplify program administration.

Rationale/Background:

Adults who turn to Minnesota's cash assistance programs see significant income changes from month to month. For instance, 44% of the families turning to the Minnesota Family Investment Program (MFIP) experience extreme income instability; in any month they have a 30% chance to have either no income at all or twice their average monthly income. This volatility is true of low wage workers in general. The budgeting method and budget periods Minnesota uses to determine monthly benefits contribute to the income instability instead of stabilizing household income and incentivizing working. This effect undermines the intent of Minnesota's public assistance programs to support work and help move households to economic stability.

Complex public assistance policies also divert eligibility workers' time, set the stage for frequent errors, and create even more stress for people in crisis who have turned to assistance. The fact that the policies differ from program to program adds to the complexity and the possibility of confusion and errors. Eligibility workers spend more time on cash assistance cases than on Supplemental Nutrition Assistance Program (SNAP) cases. In 2018, the counties spent an average of about $128 per case per month to administer MFIP cases and $42 per case per month to administer General Assistance cases. That is compared to about $37 per case per month to administer SNAP cases.

Cash assistance programs use a budgeting method no other programs use and set month-to-month budget periods, which are especially problematic for people with earnings because earnings for low wage workers often fluctuate from month-to-month. This proposal:

- Supports work by stabilizing the incomes of low wage workers receiving assistance and reducing the heavy paperwork burden currently imposed on people who get jobs while receiving assistance.
- Simplifies the process of determining benefits.
- Enacts changes in support of the Integrated Services Business Model, which counties and the department have identified as a goal.

Proposal:

This proposal builds on the mission of supporting work for people receiving public assistance and on legislation enacted in 2014 and 2015 that streamlined reporting, income calculations, and asset determination policies, by making many of those policies uniform across multiple programs, and by eliminating inefficient processes. This proposal creates more uniform methods for calculating benefits across public assistance programs and eliminates the administratively costly and time-consuming requirements of redetermining benefits every month for all Minnesota Family Investment Program (MFIP) cases and some General Assistance cases.

Cash assistance programs are forecast programs. These policy changes will lead to a change in the base funding for the programs. Temporary Assistance for Needy Families (TANF) funds are used to reduce the general fund costs for this proposal to the greatest extent possible.

This proposal will closely align Minnesota's policies for cash assistance programs with the federal Supplemental Nutrition Assistance Program (SNAP). The two cash programs would make two significant changes:

1. Stabilize benefits for six-month periods.

Benefits would be set for six-month budget periods instead of month-to-month. Households with earnings would experience more stable benefits over that six-month period. Regularly scheduled six-month reviews would examine income and household composition to determine eligibility and benefit levels for the next six months. General Assistance households with at least $100 per month in earnings and all MFIP households would now be subject to those six-month budget periods. This change means that:

- Households would still have to report changes in essential information that determine whether they are categorically eligible for the program at the time the change occurs.
- Households would still have the option to have benefits adjusted if their income fell before a scheduled six-month review.
- The programs would align with SNAP and Housing Support, which use six-month periods for calculating benefits.

2. Use more current income for budgeting benefits.

MFIP and General Assistance would use income from the last 30 days to set benefit levels for a six-month period – as SNAP and Housing Support do. Currently, benefits for a month are determined based on income from two months earlier. Minnesota is the only state that still uses this method (called retrospective budgeting) for its TANF cash assistance program. The change in the budgeting method means that:

- Eligibility workers will only need to learn one budgeting process for public assistance programs.
- The people we serve can anticipate how their income will be treated across different programs.

Impact on Children and Families:

The Minnesota Family Investment Program (MFIP) is the primary income support program provided to children in deep poverty and their families. Women are 82% of the adults enrolled in MFIP and there are approximately 48,000 children in families that have turned to MFIP. More than half the families that have turned to the program have a child younger than six.[1] As a result, these policy changes will disproportionately benefit families with children and women by simplifying and aligning budgeting and reporting processes for cash assistance programs. These families will have more predictable and stable benefits to support housing, child care, and other necessary family expenses.

[1] Minnesota Department of Human Services, Minnesota Family Investment Program and Diversionary Work Program: Characteristics of Cases and People, 2020.

Equity and Inclusion:

Cash assistance programs reflect Minnesota's racial economic disparities. Poverty rates for African Americans and American Indians in Minnesota are about four times higher than the poverty rate for white Minnesotans.[2] Unemployment rates for American Indian, African American, and Latinx workers are 2-3 times higher than white workers.[3]

African American adults are 33 percent of the Minnesota Family Investment Program (MFIP) caseload[4] but only 7 percent of state residents.[5] American Indian adults are 6 percent of the MFIP caseload but only 1.4 percent of state residents. Overall, people of color and American Indians make up 64 percent of the MFIP caseload but are 21 percent of state residents. In addition, at least 36 percent of families that turn to the program have a family member with serious health problems or a disability. African Americans are the most likely to be employed while also receiving assistance and therefore are particularly subject to the increased reporting burdens imposed on employed participants.

The paperwork burden and the unpredictability caused by program complexity add to the stress already imparted by poverty and discrimination experienced by the people we serve. Low wage workers in retail, hospitality, food service, health care, and temporary agencies account for the vast majority of adults who turn to public assistance when unemployed or underemployed. These are also the industries in which people of color and American Indians receiving MFIP are most likely to be employed.[6] These jobs are subject to inconsistent work schedules, high turnover, and no benefits. These workers rarely receive unemployment insurance. The public assistance system they turn to during a time of crisis is unnecessarily complicated. The proposed policy changes will disproportionately benefit these workers by incentivizing work and simplifying budgeting and reporting processes for cash assistance programs.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Tribal Nation offices would recognize reduced administrative burden as illustrated by the following:

- Tribal Nation eligibility workers would no longer be examining and readjusting more than 13,000 cases per month.
- A monthly, 5-page report form would no longer be used and in its place, people receiving cash assistance would complete the same form used by SNAP and health care programs for six-month reviews.
- The 14 pages in the state's manual for eligibility workers on instructions about reporting would be reduced by almost half.

Impacts to Counties:

County offices would recognize reduced administrative burden as illustrated by the following:

- County eligibility workers would no longer be examining and readjusting more than 13,000 cases per month.

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[2] Minnesota Department of Health, People in Poverty in Minnesota, 2019.
[3] Minnesota Department of Employment and Economic Development, How Does Minnesota Unemployment Compare, 2015.
[4] Minnesota Department of Human Services, Minnesota Family Investment Program and Diversionary Work Program: Characteristics of Cases and People, 2020.
[5] U.S. Census, QuickFacts, Minnesota, 2021.
[6] Minnesota Department of Employment and Economic Development, Minnesota Economic Disparities by Race and Origin, 2020.

- A monthly, 5-page report form would no longer be used and in its place, people receiving cash assistance would complete the same form used by SNAP and health care programs for six month reviews.
- The 14 pages in the state's manual for eligibility workers on instructions about reporting would be reduced by almost half.

IT Costs:
The costs below are total dollar estimates (not including Federal Financial Participation) for changes to the MAXIS and MEC^2 eligibility systems.

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll						
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)	$1,279,253	$848,708	$377,997	$507,529		
Total	**$1,279,253**	**$848,708**	**$377,997**	**$507,529**		
MNIT FTEs						
Agency FTEs						

Results:
Cash assistance programs would more effectively support working adults and help households, particularly children, move out of deep poverty and manage the destabilizing income volatility that low income households experience. Under this proposal, individuals who get jobs would no longer have to engage in monthly benefit recalculations and the uncertainty those create for their income. Housing Support introduced six-month budget periods and prospective budgeting for recipients with earnings in 2015 and saw the number of recipients with earnings more than double in the years since then.

About 44% of MFIP households experience extreme income volatility, meaning in any month they have a 30% chance of having no income or double their average monthly income. This is particularly true of those with earnings. Low wage work often provides unstable income because of unpredictable schedules and shifts. Research indicates that income volatility increases the risks of experiencing mental health problems and the rate of emergency room visits. Stable public assistance benefits for six-month periods incentivizes work for recipients and makes household budgeting more predictable and stable employment more likely.

Evidenced Based Practice	**Source**
A welfare-to-work program that combines mandatory participation in employment and training services with earnings supplements for participants who do find work.	Source: OPRE, https://www.urban.org/sites/default/files/publication/101287/from-savings-to-ownership.pdf

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			704	1,578	2,282	12,955	16,124	29,079
HCAF					-			-
Federal TANF			0	1,402	1,402	16,160	20,037	36,197
Other Funds			-	-	-	-	-	-
Total All Funds			704	2,980	3,684	29,115	36,161	65,276
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	21	Reporting - MFIP	0	826	826	9,593	11,927	21,520
TANF	21	Reporting - MFIP	0	1,395	1,395	16,153	20,030	36,184
GF	23	Reporting - GA	-	270	270	3,139	3,904	7,044
GF	21	Unearned income - MFIP	-	4	4	4	4	8
TANF	21	Unearned income - MFIP	-	7	7	7	7	13
GF	21	Unearned income - Housing Support	-	6	6	6	6	12
GF	42	Unearned income - Basic Sliding Fee	-	5	5	5	4	9
GF	11	Systems costs (MAXIS and MEC2) @ 55%	704	467	1,171	208	279	487
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

Chapters 119B, 256D, 256I, 256J, and 256P.

Change Item Title: Family First Prevention Services Act (FFPSA) Phase 3 and Operational Investments

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	13,051	20,875	23,757	23,865
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	13,051	20,875	23,757	23,865
FTE	**21**	**21**	**21**	**21**

Recommendation:

The Governor recommends investing $33.9 million in FY 2024-2025 and $47.6 million in FY 2026-27 to fund implementation and expansion of the Family First Prevention Services Act (FFPSA). This proposal will also provide funding to better ensure the Child Safety and Permanency Division (CSP) at the Department of Human Services (department) has adequate staffing infrastructure to implement complicated new programs and policies established at the state and federal level. This investment is the third phase of FFPSA implementation.

Rationale/Background:

The FFPSA is a federal law enacted as part of the federal Bipartisan Budget Act of 2018.[1] It seeks to encourage enhanced support to children and families and prevent foster care placements through the provision of evidence-based mental health and substance abuse prevention and treatment services, in-home parent skill-based programs, and kinship navigator services. The FFPSA also places stricter standards on congregate foster care settings and requires additional background studies for staff working in those settings. Changes to state statute to comply with FFPSA standards were enacted during the 2019, 2020 and 2021 legislative sessions. To meet these new requirements and support the ongoing implementation of FFPSA in Minnesota, additional staff and systems changes are necessary.

FFPSA Prevention Services Implementation

The FFPSA shifts costs for congregate foster care placements to the states, but also provides the opportunity for states to access Title IV-E[2] funding for services that were previously ineligible for Title IV-E reimbursement. This new funding stream permits prevention funding under Title IV-E for the delivery of evidence-based services that prevent out-of-home placement. While states are not required to seek Title IV-E funding for prevention services, the FFPSA gives Minnesota the opportunity to build a robust prevention program that expands the number of children and families served while utilizing collaborative efforts, research and data to deliver the most effective evidence-based services.

The FFPSA gives county child welfare agencies and tribes participating in the American Indian Child Welfare Initiative the ability to receive 50% reimbursement for federally approved services for children at imminent risk of out-of-home placement and their caregivers. The FFPSA establishes placement prevention services to strengthen

[1] Family First Prevention Services Act

[2] Federal Title IV-E is an annually appropriated program with specific eligibility requirements and fixed allowable uses of funds for foster care, kinship, adoption, prevention services, training and administrative costs. Funding is awarded to states by formula as an open-ended entitlement grant and is contingent upon an approved title IV-E plan to administer or supervise the administration of the program.

families, prevent maltreatment, and address other conditions that lead to out-of-home placement. This is an unprecedented opportunity to make transformative changes in the child welfare system. A state must develop a Five-Year Title IV-E Prevention Plan (Plan) that meets the federal requirements.

To obtain federal Title IV-E reimbursement for approved services, the state must first submit a prevention services plan approval by the federal Children's Bureau. An initial state investment is necessary to achieve the rigorous requirements outlined in FFPSA. Ongoing investments will be necessary to achieve Minnesota's vision for supporting family preservation. This vision includes:

- Building an initial program that creates a strong foundation for transformational changes in child welfare.
- Continuing to build the FFPSA prevention continuum by creating and expanding services, including kinship navigator services that focus on FFPSA values and are informed by system collaborators and families.
- Utilizing continuous quality improvement strategies that identify areas of growth and opportunity to expand both in services and those who are served.
- Coordinating with other systems, programs and initiatives to build a robust prevention continuum in and outside of FFPSA opportunities.

The capacity-building created by this proposal should result in more children being served with their families or kin prior to a potential removal from the home and placement in a foster care setting.

Kinship navigator

FFPSA amended Title IV-E of the Social Security Act to allow Title IV-E agencies the option to receive Title IV-E funding for Kinship Navigator programs that have been federally-approved and are part of a FFPSA Prevention Services Plan.

Kinship Navigator programs have a long history in Minnesota rooted in the work of the Minnesota Kinship Caregiver Association (MKCA). This association led the state in providing supportive services to informal and formal kin caregivers. In 2009, MKCA participated in a three-year federally funded project designed to enhance and evaluate these services provided to kin. MKCA dissolved in 2013 when federal Family Connection grants were ended. Lutheran Social Services of Minnesota (LSS) Kinship Family Supports now runs a similar program and that is funded in part by the Metropolitan Area Agency on Aging (MAAA).

The Department of Human Services (department) has used federal Title IV-B[3] funds to contract with LSS to develop a kinship navigator model for kinship caregivers of children not receiving foster care services and these federal funds must be used by Sept. 1, 2023. This proposal is requesting funds to expand state funding for a kinship navigator program, add a tribal community agency to provide kinship services, and evaluate the program. The program evaluation is required to receive federal approval by the Title IV-E Prevention Services Clearinghouse,[4] which would make kinship services eligible for Title IV-E reimbursement.

QRTP Assessments and QIs

To encourage states to rely less on placing children in child care institutions (congregate care), the FFPSA established stricter standards for these types of foster care placements. The new federal standards require congregate care facilities to become certified qualified residential treatment programs (QRTP's). Effective Oct. 1, 2021, Title IV-E eligible children who are placed in congregate care settings that are not family foster homes are eligible for only two weeks of federal reimbursement. After two weeks, unless a child care institution becomes a certified QRTP, no federal Title IV-E reimbursement is available to offset placement costs. This means counties

[3] The federal Title IV-B program provides grants to states for the purpose of keeping families together with services that: protect and promote the welfare of all children; prevent the neglect, abuse or exploitation of children; support at-risk families through services which allow children, where appropriate, to remain with their families or return to their families in a timely manner; promote the safety, permanence and well-being of children in foster care and adoptive families; and provide training, professional development and support to ensure a well-qualified workforce.

[4] See: the Title IV-E Prevention Services Clearinghouse

and Initiative tribes become 100% responsible for the cost of care in a facility that does not meet FFPSA requirements.

In addition to new facility requirements, the FFPSA requires an assessment to determine whether or not a child can receive services within their family or community setting instead of placement in a QTRP. This assessment must be completed by a qualified individual (QI) who can be either a licensed clinician or member of the community who becomes a trained QI professional. The assessment is to be conducted within the context of a child's culture and community, so it is critical that culturally competent QIs be available to serve children from Black, Indigenous and other People of Color (BIPOC) communities and Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) communities who are in foster care. BIPOC and LGBTQ children are overrepresented at all points in the child protection system, including placements in foster care. Parents and older youth can request a specific QI. If the Indian Child Welfare Act (ICWA) and Minnesota Indian Family Preservation Act (MIFPA) apply, a child's tribe must be involved in this decision-making process.

This proposal will provide counties, tribes, parents, and older youth with a centralized statewide pool of contracted QI's rather than have individual counties and the department contract for QI's separately. Counties will continue to have the option to designate county staff as a QI under a federal waiver. The QI is responsible for completing the QRTP assessment process, which includes:

- Interviewing the child/youth and parent(s)
- Collaborating with family and permanency team members, including school personnel, mental health professionals and others
- Completing the required Commissioner's approved Child and Adolescent Needs and Strengths (CANS) functional assessment
- Documenting required assessment findings on the QRTP assessment and recommendation form that determines whether a child's needs can be met by the child's family members or through placement in a family foster home. If the child's needs cannot be met in one of those settings, the assessment will determine which residential setting would provide the child with the most effective and appropriate level of care in the least restrictive environment. Assessment information is shared with the court.

To complete the QRTP assessment a QI must be trained and certified to administer the CANS assessment tool. All QIs must have a background check, (Minnesota Statutes, sections 299C.60 - 299C.64) and attend a two-day training on their role and responsibilities and use of the CANS. There is an annual re-certification that is required.

This proposal recommends supporting counties and tribes in meeting the federal requirements for QI's by having the department contract with one community agency to manage a statewide pool of QI's. This proposal also includes the funding necessary for the department to:

- Hire 1 FTE to manage the RFP and contracting with the community agency
- Cover the costs for QI's to maintain their annual certification on the CANS
- Cover the costs for background study checks on QI's
- Cover the costs for specific trainers in the Child Welfare Training Academy to ensure the required QI training is routinely provided.

<u>Staffing Infrastructure</u>

The work, staffing, and infrastructure of the Child Safety and Permanency Division (CSP) has grown substantially since 2015. This growth has led to a need for additional fiscal, contracting, project management, administrative support, and communications staffing to ensure that CSP is able to develop and implement policies and procedures to ensure accountability in the execution of complicated new programs.

Since March 2015, when Governor Mark Dayton's Task Force on the Protection of Children generated 93 large scale systemic policy and program recommendations for improving the pre-court portion of Minnesota's child protection system, CSP has been implementing the recommendations which has driven the need for more policy

and program subject matter experts. Additional implementation efforts driving the need for improved operations infrastructure include implementation of major federal child welfare reform stemming from the FFPSA. Additionally, in June 2022, the Office of the Legislative Auditor (OLA) released a report that made several recommendations with implications for CSP. These recommendations include the need for improvements in the provision and documentation of services offered to families to prevent child removals as well as shorter, easier to read case plans so families know the steps they need to take to pursue reunification. The recommendations also include the creation of a work group to develop training for law enforcement regarding removal of children from their home.

CSP does not have sufficient staffing for necessary complex project management, specialized fiscal staff, contracting, and staff trained in engaging meaningfully with the people we serve. Specialized staff is needed for these purposes.

Proposal:

FFPSA Prevention Services Implementation

In September 2022, the department submitted Minnesota's Prevention Services Plan to the Children's Bureau for federal approval. In order to implement the state's initial program, state investments are needed in the following areas to implement and sustain initial prevention services across the state. This proposal includes the following investments to implement Minnesota's plan:

- FFPSA requires fidelity monitoring for each service that the state implements. It also requires an overall CQI monitoring process of the state's prevention plan. These are new activities for the department, thus internal capacity must be built to complete this required task. Ensuring the state is compliant with federal prevention services fidelity monitoring, evaluation and CQI requirements requires 4 FTEs.
- FFPSA introduced new practices and procedures for local welfare agencies, representing a significant need for training.
- Based upon the department's stakeholder engagement, Motivational Interviewing (MI) is planned to be an initial prevention service. Implementation of MI will require support from the Minnesota Child Welfare Training Academy, which will also support the fidelity monitoring components. The department needs 1 FTE to implement training needs related to prevention services.
- Additional prevention services will need to be analyzed, planned, and eventually implemented. To support growth of a prevention services array the department needs two additional FTEs.
- Funding is needed to support MI fidelity monitoring requirements, including a MI coding tool or process. The cost for this work will increase as the use of MI as a prevention service expands.
- As the prevention services array continues to be developed and monitored, community and lived experience voice need to be included and compensated accordingly. This proposal includes $50,000 per fiscal year starting in FY24 to support ongoing community engagement necessary for implementation of the state's prevention services plan and fidelity monitoring.
- Transformation means change at the local level to support local child welfare agencies in service development and expansion; the addition of staff to support implementation in administration, data collection and case management; local community engagement; and training. While FFPSA allows reimbursement for evidence-based services, it fails to address other barriers to family preservation, such as basic needs, transportation, and other concrete needs that support families in achieving their goals. This proposal includes annual funding to support local child welfare agency infrastructure, staffing, and concrete support for families. The amount of this appropriation was determined based on spending on Family Assessment Response (FAR) allocations to local child welfare agencies. FAR services are similar to FFPSA in-home case management. This is roughly the amount local agencies currently use for a service that is similar to FFPSA in-home case management.
- Funding is required to expand initial prevention services, support promising practices and plan for additional services that focus on family preservation. Annual funding is requested to support expansion of

prevention services eligible for Title IV-E reimbursement in Minnesota. This appropriation would allow two new services to be piloted in various regions of the state, including evaluation expenses.
- This proposal creates a new special revenue fund where grants can retain federal reimbursement for evidenced-based prevention activities, as allowed by FFPSA.

Kinship navigator

This proposal seeks funding to continue development of a kinship navigator model for submission to the federal Title IV-E Prevention Services Clearinghouse for approval. This model would serve kinship caregivers to prevent foster care by expanding services statewide, adding a tribal community agency and evaluation of the program that is required for federal approval.

QRTP Assessments and QIs

To support counties and Initiative tribes to come into compliance with this new federal requirement, the department developed a program using one-time federal Family First Transition Act (FFTA) funds to operate a pilot program to hire 30 contracted individuals. For the past 10 months the pilot program has received on average 16 QRTP referral requests a month. This pilot has been successful and demonstrated a need to continue this support for counties and Initiative tribes to meet the QRTP assessment requirements. The pilot has also demonstrated contracting limitations and staffing needs to transition from a pilot to an ongoing program.

The federal requirement that a QI perform an assessment for children entering a QRTP is an unfunded federal mandate that in a state supervised-local agency administered child welfare system could increase costs for counties and Initiative tribes. County advocates have expressed a desire to have a centralized statewide pool of QIs managed by the department and paid for using state general funds. A state funded program would protect county property taxpayers and help ensure there are not disparities in access to QIs based upon geography or the size of a county's property tax base. Investing state funds to establish a centralized pool of QIs would also enable the department to focus on recruiting individuals from a child's community.

To implement a statewide QI program, the department would contract with a community agency for program administration. The community agency's responsibilities would include recruiting and hiring a diverse pool of QIs, managing the referral process, handling performance issues, and ensuring timely completion of QRTP assessments. This grantee would manage county and tribal agency referrals of approximately 300 assessments a year, contract with up to 100 individuals to serve as QIs, and track data or trends.

The appropriation for this proposal includes:
- Contract with a community agency to manage the program:
    - $250,000 annual cost to administer and manage the program and
    - The cost to complete 300 QRTP assessments by 100 QI's at the cost of $667 per assessment is $200,100 for QRTP assessments annually;
- 1 FTE to manage the grant classified as a 14L.
- Initial and annual QI training (including payments to QIs for attending training $7,200 annually; and purchase CANS certifications for up to 100 QIs at annually cost of $1,200.) COST: $8,400
- The cost of background studies for QIs, at $33.25 for each study. COST: $3,325;
- Cost of a contract with the Praed Foundation to maintain the evidence-based assessment tool. COST: $10,000 per year; and
- Cost for Child Welfare Training Academy to hire community trainers Child Welfare Trainer Academy trainer. COST: $16,800 annually for six two-day training.

Staffing Infrastructure

To ensure proper administration of CSP programs and implementation of complex projects to address state and federal policy changes, 12 full-time staff are needed to provide additional division operations support, including

advanced fiscal management, project management, and continuous quality improvement efforts. These four staff include:

- 1 FTE for managing and supervising the Operations Unit in CSP – (Permanent)
- 4 FTEs for project management – (Permanent)
- 1 FTEs for budgeting and fiscal management – (Permanent)
- 1 FTE for request for proposal development, contract development, and contract monitoring – (Permanent)
- 1 FTE Information Officer to assist with the significant increase in communications requests (i.e., editing, publishing)-(Permanent)
- 1 FTE to serve as a constituency services policy consultant to assist in responding to increase in constituent service requests- (Permanent)
- 1 FTE to serve as a case planning and reunification policy consultant required by OLA Evaluation Report 2022 – (Permanent)
- 1 FTE for curriculum development for law enforcement required by OLA Evaluation Report 2022 – (2 – years)
- 1 FTE to serve as a subject matter expert for SSIS case planning required by OLA Evaluation Report 2022 – (2-years)
- Additionally, to implement the recommendations of the OLA report, this proposal includes an appropriation of $75,000 for three years ($25,000 per year) for costs associated with workgroup implementation processes and stakeholder engagement for stipends, meeting facilitation, and hosting community members for input into policy and practice

Impact on Children and Families:
The capacity-building created by this proposal should result in more children being served with their families or kin prior to a potential removal from the home and placement in a foster care setting. It will also enhance the skill set of the workforce using Motivational Interviewing to better serve children and families. Improved processes and resources for budgeting, contracting, and project management will better position CSP to prioritize funding and contracting toward equity initiatives. This proposal should also help ensure that children and families who are African American, Native American, two or more races, or who may be LGBTQ have access to a qualified individual from their communities.

Equity and Inclusion:

Disproportionality among children experiencing out-of-home care remains an ongoing challenge for the Minnesota child welfare system, paralleling opportunity gaps experienced by American Indian and African American children and families, and LGBTQ youth across the state. This proposal should result in more children, including African American and American Indian children, being served with their families or kin prior to a potential removal from the home and fewer placements in residential treatment facilities. Data on these aspects will be tracked through the implementation across the state. Ensuring CSP has adequate staffing infrastructure supports proactive collaboration with county and tribal partners and improved project coordination.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Tribes participating in the American Indian Child Welfare Initiative (Initiative Tribes) will benefit from the department incorporating the QRTP assessment in the Social Services Information System as well as the having the eligibility and approval process for determining Title IV-E candidates. This will reduce administrative time and costs and may result in increased access to Title IV-E reimbursements. Ensuring the availability of properly trained

and certified QIs will help ensure Initiative Tribes can meet FFPSA requirements for placement of a child in a QRTP and may result in increased access to Title IV-E reimbursements.

Tribes will be provided additional resources to reinforce their current efforts related to family preservation. Tribes with IV-E agreements with the state will also be able to claim Title IV-E for applicable prevention services. Tribal child welfare staff will have the ability to be trained in motivational interviewing, further increasing their skill and capacity to support families. Tribes have been engaged in a number of ways, including through formal government to government consultation, information sharing and review meetings, and discussions at the ICWA advisory council.

Impacts to Counties:
Counties will benefit from the department incorporating the QRTP assessment (CANS) in the Social Services Information System as well as the having the eligibility and approval process for determining Title IV-E candidates. This will reduce administrative time and costs and may result in increased access to Title IV-E reimbursements.

Ensuring the availability of properly trained and certified QIs will help ensure counties can meet FFPSA requirements for placement of a child in a QRTP and may result in increased access to Title IV-E reimbursements. Counties have requested a statewide pool of QIs, and this investment provides support to the cost incurred by counties and initiative tribes to implement FFPSA.

Counties will be provided additional resources to support family preservation. This should result in cost savings, as fewer children will be in out of home care. Staff will be trained in Motivational Interviewing and be provided additional resources to support families in meaningful ways to support safety and well-being.

IT Costs:
This proposal includes costs to integrate the CANS assessment tool and foster care candidacy into SSIS. The projected total cost for these provisions to implement is $344,622 with ongoing maintenance cost of $71,632. The fiscal detail section of this proposal reflects state share.

The case plan summary documents will require an enhancement to SSIS at a cost of $31,601 with ongoing maintenance cost of $6,320.

Results:

This phase of FFPSA implementation should result in increased placements with relatives, increase the ability of relatives to care for children, and ensure families are able to provide the necessary supports for children who are at imminent risk of entering foster care but who can safely remain in the child's home or in a kinship placement as long as appropriate and necessary services are provided. Efforts to support children and their families at risk of out-of-home placement should reduce the actual number and length of placements and the resulting costs associated with placements.

Data on existing child welfare measures, including data by race/ethnicity and by age of child, can be found on public Minnesota child welfare data dashboard can be found on the child welfare dashboard (public). In addition, data is and will continue to be maintained on the number of allegations and substantiations of child maltreatment, as well as out-of-home placements of children, by race/ethnicity. Additional data can be found in the 2020 Child Maltreatment Report and the 2020 Out-of-Home Placement report.

Evidence-based Practice	Source of Evidence
MI is a client-centered, directive method designed to enhance client motivation for behavior change. It focuses on exploring and resolving ambivalence by increasing intrinsic motivation to change. MI can be used by itself, as well as in combination with other treatments. It has been utilized in pretreatment work to engage and motivate clients for other treatment modalities.	Source: CEBC, https://www.cebc4cw.org/program/motivational-interviewing/

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			13,051	20,875	33,926	23,757	23,865	47,622
HCAF								
Federal TANF								
Special Revenue Fund								
Total All Funds			13,051	20,875	33,926	23,757	23,865	47,622
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	45	Kinship navigator grants – Transfer to SRF	764	764	1,528	750	750	1,500
GF	45	FFPSA Implementation Grants to counties	6,100	9,800	15,900	9,800	9,800	19,600
GF	45	FFPSA evidenced-based grants – Transfer to SRF	3,000	7,000	10,000	10,000	10,000	20,000
GF	45	Grants for QI work	450	450	900	450	450	900
GF	12	Stakeholder engagement, program evaluation, motivational interviewing	443	465	908	630	790	1,420
GF	12	FFPSA Staff Infrastructure (7)	948	1,099	2,047	1,099	1,099	2,198
GF	12	Children and Families Admin (11)	2,135	2,417	4,552	2,099	2,099	4,198
GF	11	SSIS changes @ 60% state share	249	50	298	50	50	99
GF	11	Financial Operations (1 FTE)	133	153	286	153	153	306
GF	REV1	Admin FFP @ 32%	-1,171	-1,323	-2,494	-1,274	-1,325	-2,599
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	12	Children and Family Services Admin	20	20	40	20	20	40
GF	11	Financial Operations	1	1		1	1	

Statutory Change(s):

Minn. Stat. 260C.704

New section in Chapter 260

Change Item Title: Supporting Tribal Child Welfare Agencies and the American Indian Child Welfare Initiative

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	9,905	11,878	14,477	14,365
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	-
Net Fiscal Impact = (Expenditures – Revenues)	9,905	11,878	14,477	14,365
FTEs	**1**	**1**	**1**	**0**

Recommendation:

The Governor recommends investing $21.8 million in FY 2024-2025, $14.5 million in FY 2026 and $14.4 million in FY 2027 to expand and bolster the American Indian Child Welfare Initiative (Initiative). First, this proposal would support the Mille Lacs Band of Ojibwe in its ongoing efforts to build the child welfare infrastructure and programming necessary to join the Initiative. Second, this proposal would increase funding to the 3 tribal nations currently participating in the Initiative to ensure adequate funding for their Initiative programs. Finally, this proposal will provide funding to seven non-Initiative tribes to hire staff to liaise with counties to help ensure they follow best practices and state and federal laws governing child protection and child welfare work with American Indian children and families.

Rationale/Background:

This proposal recognizes and honors the sovereignty of tribal nations. It also takes one step toward reversing the grave injustices and trauma caused to American Indians by decades of government policies, including removal of tens of thousands of American Indian, Alaska Native and Hawaiian Native children from their families and tribes for placement in boarding schools for the purpose of eliminating the cultural identity of Indian children.[1]

This proposal has 3 components:

- Enable Mille Lacs Band of Ojibwe to join the Initiative.
- Increase funding for existing Initiative Tribes to help ensure they have adequate funding for their child welfare programs.
- Provide funding for tribes that are not part of the Initiative to hire staff to work with counties on state and federal child welfare laws and best practices for working with Indian children and families.

The American Indian Child Welfare Initiative

Minnesota leads the nation in the disproportionate representation of American Indian children in foster care. When compared to white children, Indian children experience a higher rate of involvement in the child welfare system from being overly reported, screened in for a maltreatment response, and selected for an investigation rather than assessment. American Indian children are about 5 times more likely to be reported as abused or

[1] For more on the Indian Boarding School era from 1819 to 1969, see: Federal Indian Boarding School Initiative Investigative Report, May 2022

neglected than White children, and 16.4 times more likely than white children in Minnesota to experience foster care.[2]

Several components that are both internal and external to the child welfare system influence these disparities: bias in identification and maltreatment reporting; child welfare worker bias; the impact of historical trauma; socioeconomic factors, including inequitable outcomes in education, health and corrections; poverty; institutional racism and discriminatory practices; and the everyday stress related to experiencing prejudicial behaviors in interactions with others.

The Initiative was authorized in 2005 as a means of honoring tribal child welfare systems serving families in a cultural context, through an Indigenous practice model lens.[3] Initiative Tribes have authority to deliver child welfare services to American Indian children and families living on the reservation. In doing so, they take on the child welfare responsibilities and costs from counties in the reservation. Currently, 3 tribes in Minnesota have implemented the Initiative – White Earth Nation, Leech Lake Band of Ojibwe, and Red Lake Nation. Mille Lacs Band of Ojibwe is poised to become the 4th Initiative Tribe.

Participating Initiative tribes have outperformed state and federal indicators in Child and Family Service Reviews (CFSR's) in areas of safety, permanency, and wellbeing. This includes intervention services for families which engaged parents in holistic healing, and retention of parents in supportive services, which created connections to identity and wellbeing and increased resilience and wellness. Parents have demonstrated longer term success and creation of recovery oriented communities engaged in culture and family wellness. Initiative tribes have exceeded federal indicators for relative placements, stability of those placements, and increased connections for children with their families – all of which are known to improve resilience and wellbeing in children. The Initiative has also provided a pathway to improved relationship building between the tribal nations and the local counties impacted by the tribal assumption of jurisdiction. In turn, this has eliminated most of the child welfare related questions of responsible agency and jurisdiction.

Mille Lacs Band of Ojibwe – Planning and Initiative Implementation

The Mille Lacs Band is in final planning stages and stands ready become the fourth tribal nation to join the Initiative in January of 2025. To do so, the Mille Lacs Band needs funding to finish planning, as well as ongoing state funding to Implement the Initiative once planning is complete.

The Mille Lacs Band Family Services program is fully capable of serving Band members with the assistance of the Initiative and it is anticipated that families will achieve improved outcomes through this model. The Mille Lacs Band has been working toward systems improvements and infrastructure readiness in the Family Services Department to implement the Initiative.

Ensuring a uniform response from a Tribal agency rather than seven individual counties will help to eliminate disproportionality in the child welfare system of Mille Lacs Band children. This proposal will also assist the Mille Lacs Band in implementing the Families First Prevention Services Act. It would also benefit local counties and reduce contentious relationships.

Four years of county SSIS data on Mille Lacs children and families were examined in the creation of this proposal. Mille Lacs families experience a high rate of assessment and investigation, and children experience a high placement rate. Maintaining family and cultural connections is essential to the well-being of American Indian children. This proposal would allow the Mille Lacs Band Family Services program to build a robust differential response and family preservation unit to meet the needs of families and provide supportive services. This model is

[2] See: Minnesota's Out-of-home Care and Permanency Report, 2020

[3] Minn. Stat. § 256.01, subd. 14b

anticipated to reduce the numbers of children in the foster care system and reduce family and community removal trauma.

Funding for Existing Initiative Tribes

White Earth and Leech Lake were the first to implement the Initiative in 2005 and have demonstrated consistent and impressive success throughout. Both tribal nations were successful in implementing a customary practice model; reducing out of home placements; and creating helping systems that worked holistically with mental health, ceremony, and substance abuse treatment programs for the entire family. Both were also successful in partnering with other tribal supportive housing programs and parent mentor programs which also aided in the long term outcomes for families.

Red Lake Nation joined the Initiative in 2021 and was immediately successful in reducing the number of children in foster care by 50% through improved differential response and creation of family preservation programming. Families have been engaged in services as the tribe implemented a cultural practice model consistent with Anishinaabe child rearing customs and practices.

The existing Initiative tribes, Red Lake Nation, White Earth Nation, and Leech Lake Band of Ojibwe, have expressed a critical need to increase their base funding. Each of the tribes has unique needs based upon their culture, traditions and the families in their communities. Their financial needs include enhancing family preservation services, addressing the increase in out-of-home placement costs and operational needs, including cost of living increases for current staff salaries, and hiring new FTEs to ensure they are fully staffed.

One specific example of the need for increased funding is that Initiative Tribes have reported an increase in placement costs for children in specialized settings related to substance abuse, mental health and behavioral health needs. Children served in these specialized settings are in need of the additional structure and stability that is required for their care.

Current law provides $3 million in annual property tax aid for out-of-home placement costs to Beltrami County, with that aid expiring after payments in calendar year 2024.[4] When Red Lake Nation took over child protection responsibilities for Indian children on the reservation, Beltrami County began transferring this property tax aid to the Tribe. Red Lake Nation will face a significant reduction in their funding when the property tax payments expire.

Funding for Non-Initiative Tribes

Minnesota's tribes that are not part of the Initiative also provide child welfare services for children and families living on their reservations. These non-Initiative tribal agencies provide culturally sensitive and responsive social services to Indian families. Some of the services they provide include crisis intervention, case management, prevention services, and out-of-home placement supervision.

There is a long-standing practice of local county social service agencies sending notice to Minnesota tribes when a parent and or child indicates they may have an association with a Minnesota tribe. The request under this section of the proposal is to support tribes in assessing a child or parent's eligibility for membership with that tribe where it is not known and work with counties to ensure state and federal laws and best practices are followed when providing child protection services to Indian children and families.

[4] See Laws of Minn. 2014, Ch. 150, Art. 4, § 6

Six of Minnesota's non-Initiative tribes[5] have requested funding to hire staff dedicated to working with counties regarding state and federal legal requirements and child welfare best practices related to Indian children, families and tribes.

Proposal:

Mille Lacs Band of Ojibwe

Mille Lacs Band requires three phases of funding.

July 1 – 2023 to June 30, 2024: Phase 1. This phase includes tribal court code changes, the development of policies and procedures which meet federal requirements, the development of a Title IV-E agreement and IV-E unit, MA agreement, and local county agreements. The creation of such a large-scale system takes time, and assistance from individuals who are aware of the requirements and steps that need to be taken, which Mille Lacs has at their disposal. There is time needed to implement Families First Preservation Service Act requirements, and hire, train and orient the staff needed to carry out the requirements of the Initiative.

Funding for Phase 1 will enable the Mille Lacs Band Family Services Program to continue infrastructure building by hiring employees dedicated to Initiative readiness and development, engaging consultants with experience in Initiative planning and implementation, beginning to provide direct services to families to improve wellbeing and enhance family preservation and reunification, and paying for standard administrative costs. The cost for this provision is $3.3 million.

July 1, 2024 to January 1, 2025: Phase 2. During this phase, Mille Lacs Band will continue to finalize a multitude of contracts and agreements required for implementation of the Initiative, and hire staff needed to implement an Initiative program. Mille Lacs Band will also develop internal codes, policies, and other systemic changes necessary to implement the Initiative. It is expected that this proposal will enable MLBO to achieve readiness to join the Initiative and begin phasing in cases from counties beginning January 1, 2025. The cost for this provision is $5.3 million.

January 1, 2025: Implementation. Once Mille Lacs Band is fully prepared to implement the Initiative, they will need ongoing funding to run their program, as is the case with the other Initiative Tribes. The cost for this provision is $7.9 million.

In addition, to support the MLBO's planning for and use of the Social Services Information System (SSIS), and ensure that all requirements/mandates are met, one temporary (3 years) unclassified employee who would be a subject matter expert dedicated to working on all the SSIS-specific needs is required. This position must apply knowledge of child welfare policies, understand the needs of the MLBO and the Initiative agreement, and understand SSIS functionality to analyze business/policy requirements and support the MLBO in using SSIS for child welfare work as they transition into being an Initiative Tribe. The cost for this provision is $141,000 in FY 2024, $165,000 in FY 2025 and FY2026.

Funding for Existing Initiative Tribes

This proposal will provide increased funding for the 3 existing Initiative Tribes in these amounts:

- $1.8 million for Leech Lake Band of Ojibwe
- $824 thousand for White Earth Nation
- $3.0 million for Red Lake Nation

Additionally, each existing Initiative Tribe and the Mille Lacs Band of Ojibwe, would receive $80,000 annually to hire 1 FTE responsible for working with counties on serving American Indian children in the child welfare system

[5] Tribes that would receive these funds are: Bois Forte Band of Chippewa, Fond Du Lac Band of Lake Superior Chippewa Reservation, Grand Portage Band of Lake Superior Chippewa reservation, Lower Sioux Indian Community, Prairie Island Indian Community, and Upper Sioux Community. The Shakopee Mdewakanton Sioux Community did not request funding.

using best practices and in accordance with state and federal laws. As described below, tribes that are currently not participating in the AICWI would also receive support for this activity.

The total cost for this provision is $5.9 million in FY2024 and ongoing.

Funding for Non-Initiative Tribes
This proposal will provide $80,000 for six non-Initiative tribes for the purpose of hiring 1 FTE each to work with counties regarding state and federal laws and best practices for serving American Indian children and families in the child welfare system.

The total cost for this provision is $480,000 in FY2024 and ongoing.

Impact on Children and Families:

Providing additional funds to the 3 existing Initiative Tribes and Mille Lacs Band to join the Initiative will help ensure American Indian children and families receive culturally based family preservation programming, and family intervention and support services intended to support family connectedness. Culturally appropriate services will address the specific needs of American Indian children and families and be attuned to the historical and present trauma they experience.

Specific to Mille Lacs Band, this proposal would improve the quality of the child welfare services that American Indian children and families receive throughout the Mille Lacs Band reservation. With more comprehensive and regional support for the Mille Lacs Band to implement a uniform response that is culturally based and engages family in a cultural context, it is anticipated that outcomes for Mille Lacs Band families will improve. It will enable the Mille Lacs Band to implement a culturally based practice model focusing on engagement and wellbeing of families. This meaningful engagement with American Indian families, relatives, and children will keep American Indian children within their families or, at a minimum, with their extended families and communities where they can continue to thrive and maintain connections. It is the intention of this proposal that more Mille Lacs Band children and families will receive child welfare case management services that are more culturally responsive and appropriate.

Providing funding to the non-Initiative Tribes will help ensure the tribes are able to work with counties to follow state and federal laws and best practices involving Indian children and families in the child welfare system. As culturally relevant and appropriate services become the norm, it is anticipated that the disproportionate overrepresentation of American Indian children in the child welfare system will be reduced.

Equity and Inclusion:

The proposal is grounded in the need for the state to address the disproportionate overrepresentation of Indian children in the child welfare system. It honors tribal sovereignty, and better ensures Indian children and families will be served in a culturally relevant manner and that children remain safely at home with their parents, relatives or kin.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

The provisions in this proposal were developed based upon requests from tribal nations and communities during the past three tribal summits.

Impacts to Counties:

Initiative Tribes assume child welfare responsibilities for American Indian children of that tribe. The affected county social service agencies are relieved of responsibility for responding to reports of abuse and neglect for those children. Counties involved in the Initiative have had decreased caseload sizes, increased resources, and decreased staffing needs as a result.

IT Costs:

Not applicable.

Results:

It is expected that this proposal will enable the Mille Lacs Band to achieve readiness to join the Initiative and begin phasing in cases from counties beginning January 1, 2025.

It will also result in tribal nations and communities having greater bandwidth for working with counties so that state and federal laws and best practices are utilized to protect Indian families from separation and trauma.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			9,905	11,878	21,783	14,477	14,365	28,842
HCAF					-			-
Federal TANF					-			-
Other Fund					-			-
Total All Funds			9,905	11,878	21,783	14,477	14,365	28,842
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
General Fund	45	Children's Services Grants - MLBO Planning & Implementation	3,337	5,294	8,631	7,893	7,893	15,786
General Fund	45	Children's Services Grants - Fully Fund Current AICWI Tribal Nations	5,992	5,992	11,984	5,992	5,992	11,984
General Fund	45	Staffing increase at non-AICWI tribal nations	480	480	960	480	480	960
General Fund	12	Children and Family Services Admin (1,1,1,0)	141	165	306	165	0	165
General Fund	REV1	Admin FFP @ 32%	-45	-53	-98	-53	0	-53
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 27-28**
			1	1	1	1	0	0

Statutory Change(s):

New section 260.786

Change Item Title: Food Security for Minnesota Families

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	32,456	13,068	12,068	11,964
Revenues	0	0	0	0
Other Funds				
Expenditures		0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures - Revenues)	32,456	13,068	12,068	11,964
FTE	**7**	**7**	**7**	**6**

Recommendation:

The Governor recommends investing $45.524 million in FY 2024-2025 and $24.032 million in FY 2026-2027 to support food security among Tribal Nations, increase base funding for the Minnesota Food Shelf Program, provide additional outreach for the Supplemental Nutrition Assistance Program (SNAP), and invest in emergency food distribution facilities across the state. Specifically, this recommendation includes the following investments:

- Tribal Food Sovereignty: $6 million in FY 2024-2025 and $4 million in FY 2026-2027 (ongoing) to support food security and food sovereignty among Tribal Nations and American Indian communities.
- Minnesota Food Shelf Program: $12 million in FY 2024-2025 and $12 million in FY 2026-2027 (ongoing) to increase base funding for the Minnesota Food Shelf Program. Base funding is currently $3.386 million per biennium.
- Capital for Emergency Food Distribution Facilities: $19 million in one-time capital grant funding in FY 2024, to be available through FY 2027, to improve and expand emergency food distribution facilities across the state.
- SNAP Outreach: $6 million in FY 2024-2025 and $6 million in FY 2026-2027 (ongoing) to support additional outreach and application assistance to Minnesotans who may be eligible for SNAP.
- Implementation Support: $2.4 in FY2024-25 and $2.4 in FY2026-2027 (ongoing) in staff infrastructure to operationalize these programs

Rationale/Background:

The first component of this proposal is designed to improve access and equity for food security programs within tribal and American Indian communities in a way that recognizes and promotes tribal food sovereignty and sustainability. This will address and seek to eliminate state barriers and food apartheid, and will also address chronic poor nutrition as a result of a history of inadequate and harmful federal government policies.

The Tribal Nations and American Indian communities in Minnesota experience greater health disparities and inequalities compared to white communities. Recent public health research by Indigenous scholars has drawn strong correlations between current health disparities and distal determinants of health like historical trauma, genocide, loss of land, and boarding schools for Indigenous communities throughout the United States, including Minnesota. In addition to historical distal determinants, current distal determinants like colonial structures and structural racism have an impact on Indigenous people's health and well-being. Tribal Nations, urban American Indian organizations, and members of the Governor's Food Security Work Group identified the needs of American Indian communities and created recommendations for the Tribal Food Sovereignty component of the proposal.

In addition to the food security needs of American Indian communities, food support continues to be in high demand across Minnesota due to the high prices for food and other necessities impacting family budgets. Minnesotans made more than 3.6 million visits to food shelves in 2021. Relatedly, Minnesota has seen a 15% increase in the number of people participating in SNAP between 2020 and 2021. Even with this growth, it is estimated that up to 41% of people with low incomes do not have access to SNAP. This increase in food insecurity is expected to persist even after the pandemic recovery period, as low-income Minnesotans struggle to meet their basic needs amid higher household costs and constrained budgets.

The proposed funding for the Minnesota Food Shelf Program and SNAP outreach reflects an emphasis and commitment to equity and uses these funds to make investments that will inform years of future system improvements. Grants to food shelves direct resources to the grassroots of the emergency food system, which has been historically underfunded. Emergency food programs address unmet food needs in a variety of ways. Families receiving SNAP often report running out of food before the end of the month. Minnesotans who do not qualify for SNAP are often left hungry, without the resources to purchase food. This proposal responds to unmet needs and systemic underinvestment in Minnesota's emergency food network.

In addition to needed investments in food and supplies, emergency food distribution facilities in Minnesota are also under strain. A recent statewide survey of food shelf clients and food shelf managers indicated that food shelves need more freezer/cooler and dry storage space in order to expand their food services to meet the demand of Minnesotans experiencing food insecurity. Food shelves reported that there was more food than they could take because they lacked capacity to safely and appropriately store the food, reporting storage and distribution challenges that had been made more problematic by the pandemic.

Proposal:

Tribal Food Sovereignty

This first component of this proposal intends to improve access and equity for food security programs within tribal and American Indian communities in a way that recognizes and promotes tribal food sovereignty and sustainability. This proposal will allocate funds to assist Tribal Nations in achieving self-determination and improve collaboration and partnership building between American Indian communities and the State. This is a new initiative building on pandemic response work and learnings from the distribution of federal emergency funds and the inequities and gaps that were discovered from the pandemic response.

Grants

The recipients of this funding will be Tribal Nations.

- $1,719,268 per year of ongoing funds to support and promote food security for 11 Tribal Nations. Allowable uses of funds may include:
    - Costs to purchase, produce, process, transport, store, and coordinate the distribution of nutritious food to individuals and families, including culturally connected food items to meet Minnesotans diverse needs.
    - Materials to support program sustainability identified by the technical assistance plan. The funds will be used to support the development of sustainable food infrastructure at the community level.
    - Technology to facilitate no-contact or low-contact food distribution and outreach models.
    - Training and technical assistance to support evolving food distribution models and effective outreach strategies for long-term public health approaches.
- $750,000 in onetime funding for culturally relevant training for building food access and sustainability. This funding would provide for trainings, travel, and facilitation costs, with the remainder providing for state staff training.

Administrative or programmatic capacity

- The Tribal Food Sovereignty component of the proposal includes 3 FTE's to manage the grant funding and provide project management and technical assistance support.

This work compliments the equity work of the Governor's One Minnesota Plan, The Emergency Food Assistance Program, Minnesota Food Shelf Program, and the Food Security Work Group. This proposal will increase food access, food security, and equity for American Indians by expanding partnerships between Tribal Nations and the department. This proposal also provides funding to Tribal Nations to support their communities' efforts for further developing food access and sustainability in culturally relevant and appropriate ways.

Increase Base Funding for the Minnesota Food Shelf Program

This proposal adds $6 million in ongoing annual investments to the existing base of the Minnesota Food Shelf Program. With increased funds, current and new grantees representing nonprofits and Tribal Nations throughout the state of Minnesota will be able to receive an increase in funds or a new grant to support food security.

Allowable uses of funds include:

- Costs to purchase, produce, process, transport, store, and coordinate the distribution of nutritious food to individuals and families. This includes purchase of culturally connected food items to meet Minnesotans diverse needs.
- Personal hygiene supplies, including menstrual products and diapers, as well as cleaning and disinfecting supplies to promote effective public health.
- Technology to facilitate innovative food distribution and outreach models.
- Training and technical assistance to support evolving food distribution models and effective outreach strategies.

This proposal includes 2 FTE to manage the increase in grant funding and provide project management support.

Capital for Emergency Food Distribution Facilities

This proposal includes a one-time capital investment of $19 million in FY 2024 to improve the infrastructure of food shelf and Tribal Nation food program facilities. These one-time funds would begin in FY 2024, for use through FY 2027. This investment will allow local food shelves to improve and expand options to meet the increasing needs of Minnesotans with low-income experiencing food insecurity. The historic under-investment in food shelves (especially in Greater Minnesota) means that in many areas of the state there are still no viable food shelf options. Additionally, providers' response to the pandemic strained already underfunded food shelf facilities. Modifications of structures/spaces and on-going wear-and-tear has exacerbated the need for significant investments in the food shelf infrastructure statewide. This funding would improve and expand food shelf facilities throughout the state. Funds would support:

- Adding freezer/cooler space and dry storage space.
- Improving the safety and sanitation of existing food shelves.
- Addressing on-going wear-and-tear and deferred maintenance of existing food shelves.

This component also includes hiring 1 temporary FTE, beginning in FY 2024 and ending in FY 2026, as capital projects of this size require sufficient administrative resources to ensure funds are distributed effectively, efficiently, and with the oversight needed to maintain program integrity.

Outreach and Application Assistance for SNAP-Eligible Minnesotans

This proposal requests $3 million annually to provide outreach and application assistance to eligible Minnesotans who are not enrolled in SNAP. This funding will help support organizations across the state to provide education, information, and assistance to help Minnesotans apply for SNAP using culturally relevant and community-driven approaches. Referrals for SNAP application assistance increased more than 40% from 2020 to 2021.

This proposal includes 1 FTE to administer the grant funding and provide technical assistance to grantees.

Impact on Children and Families:

The first component of this proposal is a holistic approach for the whole family including children, youth, and adults to build on current state initiatives and expand equitable access for food security programs in partnership with Tribal Nations and American Indian organizations. Access to culturally relevant food supports children and families to thrive in school, at work, and in their communities. Adequate food security leads to emotional, spiritual, and physical well-being that leads to long-term healthy and independent communities.

This will help create a healthy and stable foundation for Minnesota families by ensuring safe access to culturally relevant food and promoting a healthy start. Ongoing feedback from Tribal Nations has indicated that food is medicine and therefore allocating funds for Tribal Nations and American Indian organizations will lead the development of a self-sustaining food infrastructure that leads to stable lives, positive mental health outcomes, and successful communities.

Many of the activities funded in this proposal will be evidence-based practices or culturally based practices that will improve healthy food consumption and increase food security. The Food Security Work Group conducted interviews with representatives from Tribal and American Indian organizations and learned about the needs and barriers that families in their communities are experiencing with accessing food. This proposal takes a multi-generational approach by promoting food security solutions that address the needs of everyone living in a household from young children to elders.

Children represent over one-third of food shelf visits in Minnesota. Households with children also face higher rates of food insecurity than households overall. Nationwide, 14.8% of all households with children, and 15.3% of all households with children under age six, were food insecure in 2020. By comparison, the rate of food insecurity among households overall (10.5%), and among households without children (8.8%), was substantially lower.[1] In Minnesota, there were over 3.6 million visits to food shelves in 2021. Of these, children accounted for approximately 35% of food shelf visits in Minnesota, while senior visits have increased by 31% since 2019.[2]

Minnesota also saw a 15% increase in the number of people participating in SNAP between 2020 and 2021. This increase is expected to persist even after the pandemic recovery period, as higher costs for groceries and other necessities continue to strain family budgets. Almost half of the people who receive SNAP in Minnesota are children. Access to food ensures children and families have the resources to thrive in school, work, and their communities.

Equity and Inclusion:

This proposal will reduce inequities within food support programs for American Indians by providing equitable access to existing programs and new methods of food support for American Indian communities. This proposal was created based on feedback and input from Tribal Nations and American Indian communities to identify needs, gaps, and recommendations for improving equity and access to food resources. This proposal will help achieve equitable access to food and resources, staff support, and relationship building with Tribal Nations and American Indian organizations to create more equitable outcomes.

The funding for food shelves, food banks, and meal programs will increase the availability of culturally connected foods and build capacity of historically underinvested and underserved communities – specifically Black, Indigenous, people of color, and rural communities – in response to unmet needs and lessons learned throughout

[1] U.S. Department of Agriculture, Food Security in the U.S.: Key Statistics and Graphics, 2020.
[2] Hunger Solutions Minnesota, Food Shelf Statistics report, 2021

the pandemic. In July 2020, 37% of Minnesotans reported some level of food insecurity.[3] Black and Hispanic/Latino Minnesotans reported food insecurity at more than double the rate of white residents (83% of Black residents and 70% of Hispanic residents, compared to 32% of white residents).[3] Fifty-two percent of Asian residents and 55% of people of other races, including American Indians, also reported some degree of food insecurity.[3] Even before COVID-19, Minnesota showed significant disparities in who struggled to have enough to eat. Black and American Indian Minnesotans were six times as likely to be enrolled in the Supplemental Nutrition Assistance Program (SNAP) as white residents were, and Hispanic/Latino and Asian residents were about three times as likely to be enrolled in the program.[3]

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

The first component of this proposal provides funding to Tribal Nations and American Indian organizations. This proposal was generated from meetings and interviews with Tribal Nations and American Indian organization representatives via the American Indian Food Security Work Group over the course of a year and half of its work. Representatives from the Tribes and American Indian organizations have been regularly engaged on this project.

The funding in this proposal would provide support across the emergency food system – including 300+ food shelves and Tribal Nations, with an emphasis on community engagement from those with lived experience and the availability of emergency food supports. Grants to Tribal Nations recognize Tribal sovereignty and provide access to resources that have been historically unavailable to Tribes. Tribal Nations can use these designated resources to meet their needs including with entities such as food banks, regional wholesalers, small businesses, and local growers and producers. Funding flexibility allows for staffing and other gaps to create access to food.

Impacts to Counties:
This proposal does not impact counties financially and or impact county operations.

IT Costs:
N/A

Results:
The following performance measures will be used to evaluate the first component of this proposal:

- **Quantity:**
  - The number of food shelves established
  - The number of trainings provided
- **Quality:**
  - Summary reports will be created to monitor the food integrity and quality.
  - Relationships established between Tribal Nations, American Indian organizations and DHS (measured by number of meetings)
- **Result:**

[3] Wilder Foundation, New Food Insecurity Data Highlight Minnesota's Continuing Disparities and the Need for Multi-Sector Solutions, 2020.

- Fewer American Indians will experience food insecurity. Many of the activities funded in this proposal will be culturally based practices that will improve healthy food consumption and increase food security.[4]

Fewer Minnesota families will be food insecure as a result of these investments. Results will also include:

- The number of emergency food programs funded, and the grant amounts received.
- The amount of freezer/cooler equipment and dry storage space added to food shelves.
- The number application assistance referrals received by SNAP outreach organizations.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			32,456	13,068	45,524	12,068	11,964	24,032
HCAF								
Federal TANF								
Total All Funds			32,456	13,068	45,524	12,068	11,964	24,032
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	47	Children and Economic Support Grants	12,000	12,000	24,000	11,000	11,000	22,000
GF	47	Capital Project	19,000	-	19,000	-	-	-
GF	12	Children and Family Services Admin (4)	2,008	1,417	3,425	1,417	1,264	2,681
GF	11	FOD (1 FTE)	133	153	286	153	153	306
GF	REV1	Admin FFP @ 32%	-685	-502	-1,187	-502	-453	-956
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	12	Children and Families Admin	7	7		7	6	
GF	11	Financial Operations	1	1		1	1	

[4] County Health Rankings, What Works for Health

Change Item Title: Support After Foster Care

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	8,428	8,918	8,918	8,918
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	8,428	8,918	8,918	8,918
FTEs	**7**	**7**	**7**	**7**

Recommendation:

The Governor recommends investments to expand the capacity of the adolescent services unit to better serve older youth at risk of, currently in and exiting out of foster care. In addition, this proposal would provide new or increased funding for programs serving older youth, including Successful Transition to Adulthood for Youth (STAY) in the Community, Minor Connect, and Support Beyond 21 (new program). This proposal also provides funding to reduce caseloads for county and tribal case managers working with youth in extended foster care. This proposal includes funding to increase oversight to child-specific recruitment services to children and youth, ages 6 to 12 in out of home care, and to expand Public Private Adoption Initiative services to include Transfer of permanent physical and legal and custody (TPLPC). Finally, this proposal includes an appropriation for the Department of Human Services (department) to undertake a research and engagement process regarding the use of Supplemental Security Income (SSI) and Retirement Survivors and Disability Insurance (RSDI) to meet the best interests of an eligible child in foster care.

Rationale/Background:

Youth that have experienced foster care need assistance developing the skills necessary to live independently, including education and employment services, building permanent connections, and ensuring housing stability. This population is at high risk of homelessness, higher rates of pregnancy before turning 21, incarceration and lower educational outcomes. Historically, youth who leave foster care at age 18 or older face worse outcomes than their peers do.[1]

In Minnesota, youth between the ages of 15 and 17 were among the most likely to experience out-of-home care in 2020, including 3,222 youth ages 14-17, 1,106 youth ages 18-20 in extended foster care, and 105 state wards turned 18 before being adopted. Of the state wards, 21 (18.3%) continued in care after turning 18 through the extended foster care program.[2] Of the individuals who experienced homelessness in Minnesota on a single night in January 2022, 25% of those were children and youth under age 18, and 10% were young adults ages 18-24.[3]

Minor youth, 15-17 years old, who are experiencing homeless without the support of a parent or legal guardian are a difficult population to serve. A response tailored to youth 15-17 years old experiencing homelessness is needed. Intentionally hiring adults with recent lived experience will help the department develop policies and

[1] Supporting Older Youth Beyond Age 18: Examining Data and Trends in Extended Foster Care 2019. https://www.childtrends.org/publications/supporting-older-youth-beyond-age-18-examining-data-and-trends-in-extended-foster-care
[2] Minnesota Child Welfare Database 2021. https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/child-protection-foster-care-adoption/child-welfare-data-dashboard/
[3] Point in Time Count Information: Point-in-Time Count Information — Minnesota's HMIS (hmismn.org)

programs that support better outcomes and provide a first-hand Minnesota perspective of the issues youth face while transitioning out of foster care.

The Public Private Adoption Initiative (PPAI) is a program where the department contracts with private child-placing agencies to provide adoption services and adoption-related services to children under state guardianship or tribal jurisdiction. Currently, six private agencies work closely with county and tribal social services agencies to place children with adoptive families or relatives' concurrent foster families. These partnerships maximize strengths and resources of private agencies and county and tribal social service agencies to ensure that children are placed in permanent homes, and that they and their families receive the support they need.

When children in foster care cannot be reunified with their parents, transfer of permanent legal and physical custody (TPLPC) is a permanency option that allows children to be placed permanently with their relatives.[4] Children do better when placed with relatives or kin, remaining connected to their culture and community. Expansion of PPAI services to include TPLPC will increase the likelihood that a relative or kin caregiver can be engaged and supported to be a permanency resource for a child or youth waiting in out of home care. In many cases, if a relative or kin is not identified, the child could remain in care into adolescence increasing the barriers to achieving permanency and increasing the likelihood a youth would age out of foster care. Additional staff to increase education, guidance and support to county and tribal staff who provide child-specific recruitment services should increase the number of possible relative or non-relative permanency resources identified for youth, decreasing the number of youth aging out of care.

The Successful Transition to Adulthood for Youth (STAY) program is a federal funding source that has been allocated to county and tribal agencies since 1987. The STAY program promotes a successful transition to adulthood for current and former foster youth from ages 14 up to their 23rd birthday. The purpose is to support them through transitional services such as assistance in obtaining a high school diploma and post-secondary education, career exploration, training and opportunities to practice daily living skills (such as financial literacy training and driving instruction), substance abuse prevention, and preventive health activities (including smoking avoidance, nutrition education, and pregnancy prevention), and achieve meaningful, permanent connections with a caring adult. STAY also allows them to engage in age or developmentally appropriate activities, positive youth development, and experiential learning that reflects what their peers in intact families experience.

The Minor Connect program is a program designed to work with youth ages 15 to 17 that are experiencing homelessness without the support of a parent or guardian. Youth work with a case manager they otherwise would not have. The program is also supported by non-profit agencies that assist youth in returning home to their caregivers or find alternative housing options when that is not possible.

The Support Beyond 21 program is a financial assistance program that will provide youth $6,000 for one year after leaving the extended foster care program. This program is designed as a step-down program ($800 for the first 3 months, $600 the second 3 months, $400 for the third 3 months and $200 for the last 3 months) in order to assist youth with budgeting and financial literacy after leaving foster care. Youth that currently leave extended foster care are not provided any additional financial support. The department learned from young people and advocacy groups that they need more support instead of an abrupt end to financial support. Case managers will also be available throughout the state to assist these young people in transitioning out of foster care.

A recent report from The Marshall Project and National Public Radio found that most states and local governments, including some of Minnesota's local social services agencies, use SSI and RSDI payments to defray the out-of-home placement costs for an eligible child.[5] Currently, many state and local child welfare agencies, child welfare advocates, and policy makers across the nation are discussing how these payments should be used

[4] Minn. Stat., section 260C.515, subd. 4; Minn. Stat., section 256N.02, subd. 16

[5] See: States Take Social Security Benefits Of Foster Care Children To Pay For Services : NPR

in the best interests this vulnerable population of children. Legislation was introduced during Minnesota's 2022 Legislative Session that would have required the department to establish trust accounts for each child eligible for these federal funds. Before the department could implement a complex trust program for this population of children, many questions must be answered. For example, what is the financial impact on local social services agencies if these funds are no longer available, how does SSI interact with federal Title IV-E payments for a child eligible for both, and what entity outside of the department could manage a trust and how much would that cost? There are also policy and implementation questions that require engagement with a broad group of interested stakeholders, including, but not limited to individuals with lived experience in foster care, parents/guardians, foster parents, county and tribal social service agencies, and advocates for children and families impacted by the child protected system. Funding is needed to support this important research, engagement and planning process.

Proposal:

This proposal would provide six new FTEs to expand the adolescent services and permanency units. The department will intentionally recruit adults with recent lived experience for two of the new positions. Other provisions in the proposal are:

STAY in the Community: (previously known as the Healthy Transition to Adulthood (HTA) and the Healthy Transition and Homeless Prevention (HTHP) programs) will be expanded statewide. This will allow the department to provide services equitably to the overrepresented communities of African American, American Indian and lesbian, gay, bisexual, transgender and queer (LGBTQ+) youth, as well as youth living in rural Minnesota, where there is often a shortage of services and shelter. In 2015, federal law increased the age range of children served by STAY. However, despite expanding the program to more children, funding has not changed since 2006. Currently, there are over 9,000 youth eligible for services in Minnesota. Historically, Minnesota has served less than a third of the eligible youth. Additional funding will allow the department to serve more youth, offer the program statewide, and provide culturally specific programming to African American, American Indian, and LGBTQ+ youth. Annually this grant serves approximately 3,000 youth, this increase would support services to 6,000 eligible youth.

Cost: $1,958,000 in FY 2024 and $2,095,000 in FY 2025 and yearly ongoing.

Support Beyond 21: As explained above, this would be a new program. It would provide one year of additional financial support in the amount of $6,000 for youth transitioning out of extended foster care through a step-down model. This program would be administered through a grantee that will not only distribute the financial assistance, but would provide additional resources including information regarding financial literacy. This program is expected to serve approximately 175 youth per year.

Cost: $600,000 for FY 2024 and $1,200,000 in FY 2025 and yearly ongoing.

Minor Connect: This proposal would establish the Minor Connect program that was previously piloted in Hennepin County and expand it to a community in Greater Minnesota. This program serves youth ages 15 to 17 that are experiencing homelessness without a parent or legal guardian. Minors on their own are some of the least visible and most vulnerable people who experience homelessness. For example, the Minnesota 2018 Point-in-Time count identified 26 youth under age 18 in Hennepin County who experienced homelessness on their own. Yet, from March 1, 2018 to June 30, 2020, the pilot operating in Hennepin County received referrals for 156 minors. This indicates there is likely an undercount of these youth. Expanding this program would serve youth that are not currently being served and are at a very high risk of poor outcomes and homelessness.

Cost: $800,000 per fiscal year for program administration and one FTE to coordinate the program for the department.

Reduce worker caseloads: County and tribal child welfare caseloads are too high. This proposal would provide funding for additional county and tribal child welfare staff to work with youth in extended foster care. The additional funding would reduce caseload sizes for counties and tribes that participate in Minnesota's American Indian Child Welfare Initiative. Smaller caseloads will improve outcomes for youth in the foster care system by ensuring workers have adequate time to provide these youth with services. Funds would be allocated through an application process. Caseworkers that are working with at least one youth in extended foster care, and those that have a caseload of over 15 children/youth would be eligible to apply. Priority will be given to those with the highest caseloads.

Cost: $3,000,000 in FY 2024 and annually thereafter for program costs and one FTE to manage the grants.

Recruitment FTE and PPAI expansion: The proposal would also provide additional resources for county and tribal permanency efforts through increased PPAI contract amounts. Additional PPAI funding would expand services to include TPLPC arrangements for prospective relative caregivers. More funding for PPAI contracts would assist county and tribal agencies to achieve permanency and increase the number of relative and kin placement rates. In addition, county case managers often have high caseloads affecting the ability to provide extensive child-specific recruitment services to youth in need of permanency. The recruitment FTE would help ensure all children and youth, ages 6 to 21, have equitable access to effective child-specific recruitment strategies and services will help reduce the number of children who remain in foster care well into adolescence, reduce permanency timelines, and reduce the number of children who age out of foster care without having achieved permanency.

Cost: $770,000 per year for program costs and one FTE to increase technical assistance and oversight to child-specific recruitment services to youth ages 6 to 21.

Hire adults with recent lived experience: The department's policy on adolescent safety, permanency and well-being lacks the voice of individuals with recent lived experience. These young adults would assist the adolescent services unit on addressing poor outcomes by analyzing data, informing the department on policies and lived experience. The young adults would assist with the Youth Leadership Councils and other grants provided through the Adolescent Services Unit. This proposal would enable the department to add much-needed staff to support the Adolescent Safety and Permanency units. The department would recruit and hire adults with recent lived experience to fill two FTE positions. This will better ensure policies developed are grounded in real-life experiences.

Cost: Two FTEs to provide policy and data analysis and program consultation.

Hire an adolescent services unit supervisor: This position would supervise 4 existing staff who provide policy and grant management for the Chafee (STAY programs), Education and Training Vouchers, Extended Foster care, Independent Living Plan, 180-Day Transition Plan, Credit Reports, National Youth in Transition Database (NYTD) and minor parent, as well as the five new positions in this proposal.

Cost: One FTE to supervise the adolescent services unit.

Use of federal funds for children in out-of-home placement: This proposal includes funding for the department to work with an external contractor to complete a comprehensive research and engagement process to develop a plan for using SSI and RSDI funds in the best interests of children in out-of-home placement. The agency will provide a report to the legislature that includes the research and engagement findings, estimated costs, and recommendations for an implementation plan developed through this process.

Impact on Children and Families:

By hiring young adults with lived experience, the department would develop an increased understanding of foster youths' needs. This would enable the department to focus on improving services and outcomes for youth. The

department will increase oversight of adoption recruitment services for older youth and provide education and technical assistance to county, tribal, as well as private child-placing agencies on permanency. Expanding the STAY program statewide would better ensure youth throughout the state have access to independent living services. Establishing the Minor Connect program would support needed services for unaccompanied minors who are currently not being served. The establishment of the Support Beyond 21 Program will provide an additional year of financial support to youth exiting extended foster care, helping prevent homelessness. Reduce caseload sizes for counties and Initiative Tribes would better ensure caseworkers have adequate time support youth in extended foster care. Expansion of PPAI services would ensure more relative caregivers receive adoption services and consideration as a permanency resource for children and youth waiting in care, to include adoption and TPLPC. In addition, increasing department oversight of all recruitment services provided to older youth waiting in foster care would help ensure equitable access to thorough recruitment services for all youth in foster care. Overall, this proposal will create better outcomes for older youth as they leave foster care.

Equity and Inclusion:

Minnesota has some of the nation's highest racial disparities within the child welfare system. American Indian children were 16.4 times more likely, African American children more than 2.4 times, and those identified as two or more races were 6.8 times more likely than white children to experience care, based on Minnesota population estimates from 2019. These same children remain in foster care longer than white children do. Research shows LGBTQ+ youth are overrepresented within the child welfare system. Minnesota does not collect data on the number of foster youth who identify as LGBTQ+, however, some studies have found that about 30% of youth in foster care identify as LGBTQ+.[6] There is also an over-representation of youth with disabilities. Approximately 25% of youth entering care in 2020 and approximately 31% of youth continuing in care had an identified disability that further impairs their ability to achieve and sustain stable employment and housing. Homelessness is a race equity issue. American Indian, African American and youth in the LGBTQ+ community are overrepresented among people experiencing homelessness.

This proposal would better ensure that more children of color and American Indian children would achieve permanency through adoption or TPLPC with relatives and kin than they do now. Expanding services for youth would better ensure the entire state has access to independent living services, and that culturally specific programming would be available for children of color and American Indian children, and LGBTQ+ youth. During the previous Minor Connect pilot, 61% or the youth served identified as African American. Providing services and resources to older foster youth would help prevent homelessness for this population in which African American youth are over-represented.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

There will be a positive impact on Initiative Tribes because they will have an opportunity to apply for funding to decrease their caseloads for those working with youth in extended foster care. The department would provide funding to Initiative Tribes in order to hire staff, ensuring manageable caseloads. It will not increase expenditures for tribes; however, it will provide additional support for Tribal case management for the youth they serve. In addition, the other provisions of this proposal will provide statewide access to community services provided through state grants and additional programming after age 21. The ability for PPAI agencies to expand services will assist tribal staff in their efforts to achieve permanency for children and youth on their caseload by increasing engagement with relatives and providing additional placement supports. Tribal staff who are involved in PPAI

[6] https://youth.gov/youth-topics/lgbtq-youth/child-welfare#:~:text=Studies%20have%20found%20that%20about,youth%20not%20in%20foster%20care.

cases will need to be actively engaged in the review process, including development and implementation of a new plan or new plan components.

Impacts to Counties:

There will be a positive impact on counties because they will have an opportunity to apply for funding to decrease their caseloads for those working with youth in extended foster care. The department would provide funding to counties in order to hire staff, ensuring manageable caseloads. It will not increase expenditures for counties; however, it will provide additional supports from the state for case management services the youth receive from the local agency. In addition, the other provisions of this proposal will provide statewide access to community services provided through state grants and additional programming after age 21. All of these efforts are to improve outcomes for older youth in and/or transitioning out of foster care. The ability for PPAI agencies to expand services will assist county staff in their efforts to achieve permanency for youth on their caseload, increase engagement with relatives and provide additional placement supports. County staff who are involved in PPAI cases will need to be actively engaged in the review process, including development and implementation of a new plan or new plan components.

Results:

- PPAI: Currently, the PPAI program monitors PPAI performance on the following measures: amount of contract funding utilization, number of adoptive placements, number of relative engagement services, number of relative and non-relative adoption home studies completed, number of child-specific recruitment services provided, permanency outcomes for youth receiving child-specific recruitment services, number of adoptive placement disruptions, and number of post-adoption services completed.
- STAY in the Community: Currently, the program monitors performance on the following measures: number of youth served; number of independent living plans; number of group and individual independent living skills sessions; youth outcomes regarding homelessness, incarceration, parenting, substance abuse, education, employment, permanent connections, transportation, financial literacy, housing, preventative health activities, and social-emotional wellness.
- Minor Connect: The Minor Connect pilot began in 2018 and ended in 2020. The goal of Minor Connect is to provide minors with housing stability, such as living with parents, relatives, supportive friends, or supportive housing programs. Too often minors find themselves in unstable housing situations, such as couch hopping, staying in shelters or living in the streets. This table shows the housing situations when minors entered the Minor Connect pilot and when the Minor Connect pilot ended:

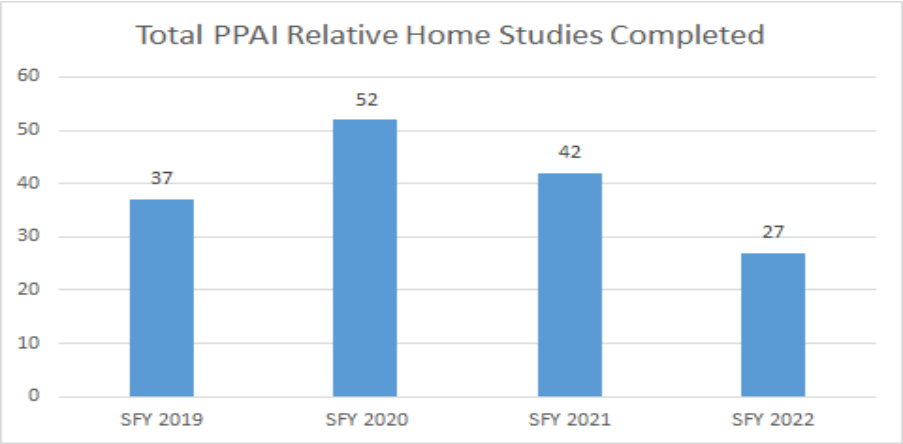
Housing	Intake*	Discharge**	Ongoing services***
Living with parents	10%	28%	16%
Living with relatives		16%	21%
Living with friends		17%	18%
Couch hopping with family/friends	60%	1%	
Shelter	21%	2%	5%
Unsheltered	2%		5%
Transitional living program	1%	2%	8%
Host home		4%	8%
Permanent supportive housing		15%	8%
Market rate rental			5%
College campus		1%	3%
Other	7%	13%	3%
Not recorded		2%	

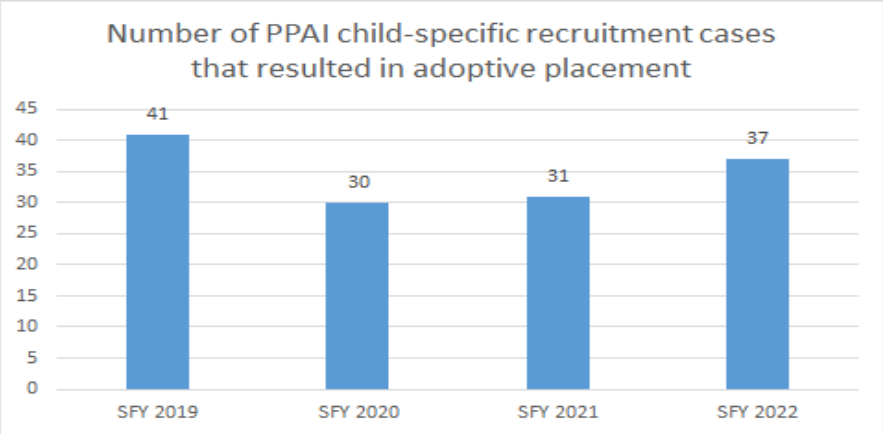
*N=156

**N=118; Discharged from Minor Connect pilot

***N=38; Receiving ongoing services by community provider after pilot

The following tables illustrate:





- Support Beyond 21: Data will be collected on how many youth are being served, as well as a survey at the end of the program to receive feedback from youth directly on the program and how it assisted them in transitioning out of foster care.
- Caseload Sizes: Counties and tribes will have an opportunity to apply for these grants in order to reduce caseload of those working with youth in extended foster care. We will be asking the agencies that receive the grants to provide feedback on how effective the program was in increasing contact and improving outcomes for youth aging out of foster care. We are especially interested in ensuring all youth have multiple supportive adults that are committed to assisting these youth in the future.
- Hiring adults with recent lived experience: By hiring adults with lived experience, the department hopes to improve outcomes of youth transitioning out of foster care. This will include better methods and tracking youth that leave foster care without a permanency outcome.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			8,428	8,918	17,346	8,918	8,918	17,836
HCAF								
Federal TANF					-			-
Other Fund					-			-
Total All Funds			8,428	8,918	17,346	8,918	8,918	17,836
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	45	STAY in the Community	1,958	2,095	4,053	2,095	2,095	4,190
GF	45	Support Beyond 21	600	1,200	1,800	1,200	1,200	2,400
GF	45	Minor Connect	800	800	1,600	800	800	1,600
GF	45	Grants to reduce county caseloads	3,000	3,000	6,000	3,000	3,000	6,000
GF	45	Increase to PPAI	770	770	1,540	770	770	1,540
GF	12	CFS Admin - SSI/RSDI Research	500	0	500	0	0	0
GF	12	Children and Family Services Admin	1,279	1,395	2,674	1,395	1,395	2,790
GF	11	Financial Operations	133	153	286	153	153	306
GF	REV1	Admin FFP @ 32%	-612	-495	-1,107	-495	-495	-990
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	Financial Operations	1	1	1	1	1	1
GF	12	Children and Family Services Admin	6	6	6	6	6	6

Change Item Title: New Non-Caregiver Sex Trafficking Response Path

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	85	17	17	17
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	85	17	17	17
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends investing $102,000 in the FY 2024-25 biennium and $34,000 in the FY 2026-27 biennium and ongoing to fund implementation of an enhanced child protection response to reports of child sex trafficking. MN.IT will use these funds for programming the new track in the Social Services Information System (SSIS). There is no base budget for these activities.

Rationale/Background:

Between July 2017 and June 2022, child welfare agencies in Minnesota received 2,340 reports of sex trafficking or sexual exploitation of children.[1] In that time, a total of 73 agencies received reports, and 42 counties received 10 or more reports. Out of the total number of reports, 727 were screened in for a child protection investigation via sex trafficking (350), sexual exploitation (357), or both (20). These investigations included 631 alleged child victims. Based on a random sample review of reports, 19% of these reports allege victimization of youth by parents, guardians, or other relatives, and can be any age (17% under age 12).

In 2015, federal law defined reports of sex trafficking and sexual exploitation, regardless of the relationship between the alleged perpetrator and the youth, as "sexual abuse".[2] State law adopted a conforming definition effective May 29, 2017.[3] As a result, all reports of child sex trafficking in Minnesota now require a child protection family investigation. For all other maltreatment types, child protection agencies only have authority to investigate reports against alleged offenders who are caregivers, parents, or household members.[4]

A sexual abuse investigation requires that face-to-face contact with a child be made within 24 hours of receiving the report to assess the child's safety.[5] In addition, the child protection agency is required to contact the alleged offender and offer the opportunity for an interview. All child protection and law enforcement investigations must be cross-reported and coordinated.

The investigation response was designed for reports involving families and caregivers who live with the child victim. Requiring child welfare contact with the alleged sex trafficker is problematic for youth, families, child welfare staff, and partners. County and tribal child welfare agencies report that contact exposes the victim and can lead to:

[1] Data from the Social Services Information System (SSIS), Minnesota's statewide automated child welfare information system
[2] Public Law 114-22, 2015
[3] Minn. Stat. § 260E.03.18
[4] Minn. Stat. § 260E.14, subd. 2
[5] Minn. Stat. 260E.20, subd. 2

- Retaliation or threats toward the youth and family
- Re-entry into trafficking or exploitation
- Threats to worker safety
- Undermining or jeopardizing the law enforcement investigation of the sex trafficking scheme
- Traumatizing the child and family by notifying the trafficker and exposing them to an investigation of the non-caregiver sex trafficker.

The child welfare system requires a new response track that eliminates the need for contact between the alleged non-caregiver sex trafficker and local child welfare agency staff. This will improve safety outcomes for children and families and provide more victim-responsive services for trafficked youth in Minnesota.

This proposal was developed by the Department of Human Services (department) Child Trafficking and Exploitation Work Group, which includes youth, parents, survivor subject matter experts, advocates, counties, tribes, law enforcement, and other state agencies. The concerns youth had regarding safety and potential harm related to contact with non-caregiver alleged sex traffickers was the paramount issue that guided the creation of the non-caregiver sex trafficking assessment.

Identical legislation creating a new response path for non-caregiver sex trafficking was introduced during the 2020 session as HF 3780 (Edelson)/SF 3787 (Hoffman) and in the 2021 session as HF 1943 (Pinto)/SF 1729 (Hoffman). During the 2022 session, the human services and judiciary/civil law committees in both the House and Senate recommended the bill to pass on unanimous votes.

Proposal:

This proposal creates an enhanced child welfare response that will improve safety and better meet the individualized needs of child victims and their families. This will be accomplished through establishing a new non-caregiver sex trafficking assessment track in Minnesota law.

Through the new track, child welfare agencies will perform an assessment of child safety, risk of subsequent child maltreatment, and strengths and needs of the child and the family. Unlike the current process for all reports of sex trafficking and sexual exploitation, the non-caregiver sex trafficking assessment will not include a determination as to whether child maltreatment occurred but will determine the need for services to address the safety of the child and family members, and the risk of subsequent maltreatment. Law enforcement will handle contact with an alleged trafficker, not the child welfare agency. This response track will be assigned only when sex trafficking by a non-caregiver is alleged. Reports of caregiver sex trafficking will continue to be investigated to determine if maltreatment occurred.

This proposal would be effective August 1, 2024, which allows time for changes to the Social Services Information System (SSIS), Minnesota's statewide automated child welfare system, and for development of guidance and training to support implementation. This cost for this proposal is entirely to pay for updates to SSIS.

Impact on Children and Families:

This proposal will protect the safety of children and families by diverting non-caregiver sex trafficking reports from the family investigation track into the new non-caregiver human trafficking assessment track. Doing so will allow child protection agencies to focus on assessing the safety and service needs of the alleged child victim and their family or caregivers, while law enforcement pursues the criminal investigation.

Equity and Inclusion:

This proposal will improve the child welfare response to trafficking and exploitation of all youth. The new response path is designed for children of all ages and is inclusive of all genders, nationalities, races, cultural backgrounds, political statuses and abilities.

Data from SSIS indicates that there is an over-representation of children of color and American Indian children, who are victims of sex trafficking or sexual exploitation. From June 2017 through April 2022, 13% of child victims in child protection sex trafficking or sexual exploitation investigations were Indian Child Welfare Act (ICWA)-eligible (16% in sex trafficking investigations). National research shows that LGBTQ children (as high as one in four alleged victims), foreign nationals and children living with disabilities are also at high risk for sex trafficking and exploitation.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Like the impact on county child welfare agencies, the American Indian Child Welfare Initiative tribes would be impacted both during initial implementation of the new assessment response and long term as the caseworkers conduct assessments. Department staff conducted engagement with tribal social services agencies during development of this proposal. This outreach included one-on-one meetings with American Indian community organizations and tribal representatives, trainings and discussions in collaborative tribal councils and networks, and meetings with indigenous survivors of trafficking and exploitation.

Impacts to Counties:

The proposal will require county child welfare staff to modify their screening and intake processes, review new guidance, and access updated training on the new response and documentation. After this initial implementation, the non-caregiver sex trafficking assessment response to non-caregiver sex trafficking reports may decrease the number of caseworker hours per case. This proposal will also reduce potential harm to caseworkers, alleged victims and their families. This proposal does not affect counties financially because they are already required to respond to all reports of sex trafficking.

More than 25 counties have participated in the development of the non-caregiver sex trafficking assessment response over the past five years, largely through the department's Child Trafficking and Exploitation Work Group.

IT Costs

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll	140,748	28,150	28,150	28,150	28,150	28,150
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)						
Total						
MNIT FTEs	140,748	28,150	28,150	28,150	28,150	28,150
Agency FTEs						

Results:

Since May 29, 2017, the department has collected data regarding the quantity of reports, demographics of victims, and maltreatment determinations. Through the new response path, the department expects to see improved response to reports involving sex trafficking of children and youth, increased safety of the child/youth, clearer roles between local child welfare agencies and law enforcement, and improved assessment and access to comprehensive services for youth and families.

Fiscal Detail

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			85	17	102	17	17	34
HCAF					-			-
Federal TANF					-			-
Other Fund					-			-
Total All Funds			85	17	102	17	17	34
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	SSIS changes @ 60% state share	85	17	101	17	17	34
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

Multiple in Chapter 260E

Change Item Title: Employment and Income Verification for Public Assistance Programs

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
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:

The Governor recommends investing $2 million in fiscal years 2024-2025 and $2 million in fiscal years 2026-2027 to support accurate and timely employment and income verification for public assistance program eligibility through a third party contract.

Rationale/Background:

Currently, many large employers use a third party vendor, such as The Work Number (TWN), to provide employment and wage verification to all employee income verification inquires. Counties are not able to obtain timely income verification for clients employed by these employers without using the third party vendor.

In 2011, the Department of Human Services (DHS) piloted a program with six counties for online income verification, and in 2014 entered into a contract with The Work Number (TWN) to provide online income verification for employees of businesses that used the TWN service. This was used by DHS and its county partners for both healthcare and non-healthcare programs, including Medical Assistance (MA), the Minnesota Family Investment Program (MFIP), the Child Care Assistance Program (CCAP), and the Supplemental Nutrition Assistance Program (SNAP). The costs were primarily covered by a 90% federal contribution made available through Medicaid funds.

Following passage of the Patient Protection and Affordable Care Act, the new Federal Data Services Hub eliminated the need for Minnesota to use the service for a large portion of public health care program recipients. By 2016, Minnesota's public health care programs were largely no longer utilizing TWN, eliminating the primary financial support for the contract DHS had entered into with the vendor. DHS engaged county partners to re-assess their use of the tool, and counties responded by indicating that TWN was a critical tool for efficient, timely, and accurate employee income verification.

In addition to the primary use of TWN as a valuable service for CCAP, SNAP, and MFIP verifications, TWN continues to be used as a tool for verifying earned income for those public health care program enrollees whose eligibility is determined outside the IT system that utilizes the Federal Data Services Hub. In particular, TWN is an effective tool to verify income for people enrolled in MA for employed persons with disabilities and for MA for seniors age 65 or older who may supplement retirement income via a part-time job. Following the end of the federal public health emergency, Minnesotans enrolled in health care programs will undergo renewal of their eligibility, as the temporary COVID-19 policies that have permitted continuous coverage end, and programs gradually return to normal policies and operations. For MA cases that do not have access to the Federal Data

Services Hub, TWN will be an important electronic verification tool, enabling eligibility workers to forgo requests for paper paystubs and lifting the burden of providing paper proof from enrollees with earned income.

Due to the continued use of TWN by DHS' county and tribal partners for non-healthcare public programs and for certain MA populations, the funding needed to sustain this effort has exceeded ad-hoc internal funding requests. DHS has continued to support this effort through temporary extensions of its contract with TWN, with the understanding that a permanent funding solution was still needed. Without a permanent funding solution, DHS will need to withdraw financial support for contracting with this third party vendor.

A central contract managed by the state allows for a lower overall cost for electronic income verifications. The current contract is structured based on contracting for a certain number of verifications. The larger the number of verifications purchased, the lower the cost per verification. Costs would be significantly higher if counties had to procure individual contracts for TWN services.

Proposal:

This proposal invests $2 million in fiscal years 2024-2025 and $2 million in fiscal years 2026-2027 to provide a partial, ongoing funding solution for DHS' contract with The Work Number (TWN), allowing the service to continue for counties utilizing it as a tool for employee income verifications for non-healthcare public programs and certain MA populations. This funding will partially support continued use of this accurate and timely employee income verification tool for program eligibility through a third party contract. If the contract is higher than this request, counties might be asked to contribute, or the number of hits available in the contract might be reduced. This will result in additional work for counties, and burdens and delays for families.

Year to year changes in the number of transactions purchased from the Work Number have been difficult to predict. However, in recent years, use of the Work Number increased dramatically is expected to continue to grow. Transactions grew by over 20% in both FY 2020 and 2021 and by 43% in FY 2022.

TWN provides wage and employment verification services for many companies nationwide. The list of employers using it as a service is growing, and these employers refer any inquiries for employment verification to TWN. Based on feedback received from DHS' county partners, TWN continues to be a valuable tool: The vendor provides an online service for income verification inquiries, returns all income related to a Social Security Number rather than just income for the specified person and employer, and provides instant results for all employee income verification requests. This proposal addresses continued reliance among counties on ongoing access to these services.

Impact on Children and Families:

TWN is used for a number of public assistance programs serving low-income children and families, including CCAP, MFIP, and SNAP. TWN provides timely and accurate employment and wage verification for DHS' county and tribal partners and serves as an efficient eligibility tool for children and families served by public assistance programs. TWN allows counties and tribes to provide better customer service to low-income children and families in need of assistance and helps ensure that public dollars are supporting qualifying Minnesotans.

Equity and Inclusion:

Racial and ethnic disparities in Minnesota are prevalent across a range of economic measures, including income levels, poverty rates, and rates of unemployment.1 These economic disparities often mean that people of color and American Indians are disproportionately likely to turn to public assistance programs that help supplement low-incomes and provide a safety net during periods of wage volatility or unemployment. For instance, people of

[1] Minnesota Department of Employment and Economic Development, "Minnesota Economic Disparities by Race and Origin," 2020. https://mn.gov/deed/assets/061020_MN_disparities_final_tcm1045-435939.pdf.

color and American Indians comprise approximately 45% of the SNAP caseload,2 64% of the MFIP caseload,3 and 68% percent of the CCAP caseload,4 while representing approximately 22% of the state population.5 This proposal also impacts vulnerable populations on public health care programs, including MA for employed persons with disabilities and MA for seniors age 65 or older who may supplement retirement income via a part-time job. The paperwork burdens and complexities of public assistance programs add to the stress already imparted by the experience of poverty and wage or employment instability. Using a third-party income verification system such as The Work Number increases access and relieves some of the administrative burden placed on families when they turn to cash, food, or childcare assistance during periods of economic hardship.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Access to TWN is important for tribal administration of human services programs. White Earth Nation and Red Lake Nation are the two tribes that use TWN in their administration of TANF, SNAP and CCAP. While this proposal was not identified during the 2021 or 2022 tribal summits as a tribal priority, tribes have indicated in previous discussions with DHS that TWN is very important to them in serving their tribal members. If the state were to discontinue its contract with TWN, tribes that administer public assistance programs would need fund their own contract with a third party vendor to verify wage and employment information for public assistance participants.

Impacts to Counties:
Access to TWN is important for county administration of human services programs. Counties have expressed strong interest in seeing access to TWN continue. Continued state support for this tool has been noted as a priority among counties at numerous legislative engagement sessions over the past several years, and the Minnesota Association of County Social Service Administrators (MACSSA) included state funding for TWN in its legislative platform in 2020, 2021, and 2022.[6] Without a full and permanent funding solution for DHS, the fiscal responsibility for continued access to TWN may fall on individual county budgets. If the state were to discontinue its contract with TWN, counties would need fund their own contract with a third party vendor to verify wage and employment information for public assistance participants.

IT Costs:
N.A.

Results:
64 of 78 county agencies responded to DHS' 2016 survey assessing the use of TWN among its county partners. Of those who responded to the survey, 92% used TWN for employee income verifications, and only 18% had their own online service contract. In addition, 84% rated continued access to the service as "very important" or "extremely important," and 74% responded that a discontinuation of the service would have either a "highly

[2] Minnesota Department of Human Services, *Characteristics of People and Cases on the Supplemental Nutrition Assistance Program*, 2018. https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5182M-ENG.
[3] Minnesota Department of Human Services, *Minnesota Family Investment Program and Diversionary Work Program: Characteristics of Cases and People*, 2018. https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4219U-ENG.
[4] Minnesota Department of Human Services, *Child Care Assistance Program: State Fiscal Year 2021 Family Profile*, 2022. https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6664I-ENG.
[5] U.S. Census Bureau, "Quick Facts," 2021. https://www.census.gov/quickfacts/fact/table/MN,US/PST045221.
[6] Minnesota Association of County Social Service Administrators (MACSSA), "Legislative Positions." http://www.macssa.org/legislative/index.php.

negative" or "extremely highly negative" impact on their business. The table below shows the number of annual transactions made using TWN by fiscal year.

FY	Annual Transactions	
2018	175,039	
2019	181,437	4%
2020	220,286	21%
2021	267,676	22%
2022	383,165	43%

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			1,000	1,000	2,000	1,000	1,000	2,000
HCAF								
Federal TANF								
Other Fund -- Systems								
Total All Funds								
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	12	Children and Families P/T Contract	1,000	1,000	2,000	1,000	1,000	2,000
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

N.A.

Change Item Title: Expanding Child Care Supports for Foster Care and Relative Caregivers

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	89	12,256	30,088	30,521
Revenues	0	0	0	0
Other Funds				
Expenditures	0	(498)	(1,126)	(1,165)
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	89	11,758	28,962	29,356
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends changing the Child Care Assistance Program (CCAP) definition of applicant and family to include foster care families, relative custodians, and successor custodians or guardians. This recommendation increases access to affordable, high-quality child care for these children and 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 children are well cared for and prepared to enter school. The program typically serves approximately 30,000 children from 15,000 families each month. Basic Sliding Fee (BSF) child care assistance helps eligible families who do not receive Minnesota Family Investment Program (MFIP) or Diversionary Work Program cash assistance pay for child care costs while parents participate in employment and/or approved education programs or job search activities. In State Fiscal Year 2021, the Basic Sliding Fee (BSF) Program served 12,209 children from 6,158 families.

Currently, to receive CCAP, the applicant must be either (1) an eligible relative caregiver or (2) a legal guardian under Minnesota Statutes[1] or tribal law. Generally, legal guardianship is granted when parental rights have been terminated or the parents are deceased. This narrow definition of legal guardian excludes many other types of custody arrangements, including cases where a child has been placed in foster care, or there has been a transfer of permanent legal and physical custody (TPLPC) of a child in foster care to their relative foster parent.

Children are placed in foster care[2] to ensure their safety or to access treatment. A child in foster care is under the placement and care responsibility of a local social services agency, and in most cases, is placed away from their parent/guardian. While there are several types of foster care settings, this proposal focuses on family foster home settings in which there is an individual or family who is typically licensed for child foster care. Northstar Foster Care (NFC) provides financial assistance to foster parents on behalf of eligible children in foster care to help support their care; foster care providers receive foster care payments on behalf of children in their care.

[1] Minn. Stat. § 119B.011 subdivision 13

[2] "Family foster home" means the home an individual or family who is licensed for child foster care (Under Minn. Stat. § 245A) or licensed or approved by a tribe in accordance with tribal standards with whom the foster child resides. Family foster home includes an emergency unlicensed relative placement (Under Minn. Stat. § 245A.035).

A TPLPC is one of two permanency options for children in foster care who cannot be reunified with their primary caregivers, the other being adoption. The adult caretakers in TPLPC situations typically would have first served as children's foster parents, and under statute must be considered a child's relative.[3] Following a court-ordered TPLPC, these adult caretakers are known in statute as the "permanent relative custodians"[4] or "permanent legal and physical custodians"[5] of a child who had been in foster care and have primary rights and responsibilities for a child's protection, education, care, supervision and decision-making on behalf of the child. Northstar Kinship Assistance (NKA) provides financial assistance to relative custodians on behalf of eligible children in their care following a TPLPC. Many (though not all) relative custodians receive NKA payments on behalf of children in their care.

The narrow definition of legal guardian in CCAP statutes has a history of causing confusion for local agencies and applicants. Since 2010, Department of Human Services (department) CCAP staff have addressed several policy questions from local agencies about the definition of legal guardian for the purpose of CCAP eligibility. In 2019, a local agency approved a CCAP application submitted by a permanent relative custodian in error. Later, they terminated the applicant's child care assistance, resulting in an appeal. The applicant had permanent legal and physical custody of a child,[6] but for the purposes of CCAP eligibility, this applicant was not the child's "legal guardian."

Though the decision to terminate the applicant's child care assistance was affirmed by the human services judge, the State of Minnesota Ombudsperson for Families said that the applicant not being a legal guardian "is a matter of semantics" because for all purposes the applicant, as a legal custodian, "has the same rights, responsibilities, and decision-making as a parent or guardian."[7] Additionally, the ombudsperson for American Indian Families reviewed the appeal and had concerns about the way CCAP staff advised local agencies to apply the definition of legal guardian. The ombudsperson recommended the department amend its policy to include "legal custodian" to be in the same category as legal guardian.

State and federal law include a preference for relative placement for children in foster care, including as permanency options when children cannot be reunified with their parents.[8] Placement with relatives helps minimize trauma children experience when they are removed from their homes. Relatives typically have the same or similar cultural and family traditions and norms and can support children in developing a positive sense of self and a better understanding of their heritage.[9] Unfortunately, relatives also tend to have lower incomes than non-relative providers and need access to services that can support them in providing foster care and permanent placement for children.[10].

While some children's NKA or NFC payments may include a small child care allowance, based on an assessment of their child care needs through the Minnesota Assessment of Parenting for Children and Youth (MAPCY), in all cases, the amount of the child care allowance is not enough to cover full time child care. The high cost of child care is a burden and deterrent to relatives and others who may otherwise provide temporary foster care or become a child's permanent relative custodian. Expanding the statute associated with the CCAP definition of applicant and family would better ensure children who must be placed in foster care can remain with relatives temporarily in foster care and, if reunification is not possible, on a permanent basis through TPLPC.

[3] Minn. Stat. § 260C.007
[4] Minn. Stat. § 260C.151, subdivision 4
[5] Minn. Stat. § 260C.515, subdivision 4
[6] Pursuant to Minn. Stat. § 260C.515
[7] The Decision of State Agency Appeal discusses this more in depth.
[8] Minn. Stat. § 260C.212, subdivision 2; 42 U.S.C. § 671 (a)(19)
[9] See, for example, Working With Kinship Caregivers
[10] See, for example, This report from Casey Family Programs

Of the 56 CCDF states and territories, many recognize custody arrangements outside of legal guardianship for the purposes of applicant eligibility for their child care subsidy program:

- In 46 states and territories, relative caretakers are eligible to apply for subsidies
- In 34 states and territories, non-relative caretakers are eligible to apply for subsidies. Depending on the state, non-relative caretakers can be non-relatives who are acting in loco parentis, have full-time physical custody of the child, or meet other conditions.
- Minnesota is one of six states where foster families are not eligible for the child care subsidy.

Proposal:

This proposal would increase the number of families who are eligible to receive CCAP through BSF by expanding the definition of applicant and family to include foster care families, relative custodians, and successor custodians or guardians. The total cost of this proposal is $13.3 million in FY 2024-2025 and $64.48 million in FY 2026-2027 from the state general fund.

These numbers assume an increase in costs for BSF and a savings in costs for Northstar Care for Children. Cost drivers include an increase in the number of potential families serviced through BSF and a decrease in the number of children receiving child care allowance through Northstar Care for Children. The costs are paid for by increasing the CCAP BSF grant fund. The additional operating costs are the MN.IT costs to change and maintain the MEC^2 system.

This proposal assumes families will use CCAP for child care payments rather than the Northstar child care allowance. Increases to the monthly payment amount are based on assessed need for child care. There is a higher allowance available for children ages birth-6 in NFC (up to $448 per month in SFY 2023) than there is for children ages birth-6 receiving NKA (up to $224 per month in SFY 2023; for some children age 6 receiving NKA, up to $448 per month in SFY 2023). Children ages 7-12 in NFC or receiving NKA are also eligible for this allowance (up to $224 per month in SFY 2023; for some children ages 7-12 receiving NKA, up to $112 per month in SFY 2023). Families receiving CCAP are not eligible for a Northstar child care allowance.

This proposal also assumes that 75% of children whose relative custodians receive NKA will receive CCAP over the NKA benefit and 40% of children whose foster parents receive NFC will receive CCAP over the NFC benefit. This proposal also assumes 75% of children whose relative custodians do not receive NKA will receive CCAP. The caregivers must meet all CCAP eligibility requirements (i.e., income and activity requirements) in order to receive the CCAP assistance. NKA and NFC participants who choose to receive CCAP would not receive a child care allowance in their monthly NKA or NFC payments.

This proposal will support children and the caregivers responsible for them by providing continuous, consistent child care assistance and care through CCAP. This proposal supports families that are providing temporary care for children in foster care, and families providing permanent care for children formerly in foster care, in affording childcare while they are working.

Effective date: August 25, 2024 to accommodate changes to MEC^2, department development of new guidance issued to local agencies, and department outreach to agencies, advocates and others who work with families who might benefit from this change.

Impact on Children and Families:

Expanding the definition of family would allow children in kinship and foster care situations to receive CCAP if their caregivers met the other eligibility qualifications, and to have access to affordable childcare, particularly for tribal communities who frequently do not terminate parental rights. By making CCAP funding accessible to relative custodians and foster parents, access to child care is improved or maintained, which supports the child's development, particularly in the early years. This proposal affects children when they are moving from their legal parents or guardians into foster care, and from foster care into permanency with a relative custodian, reducing

trauma to children who are experiencing family disruption. This proposal affects families by supporting extended family members who want to take care of children but may not have the financial means to do that.

CCAP currently provides nearly 15,195 children of color access to child care every month, and approximately 53% of all children served are African American. This tracks with the reality that Minnesota's American Indian and African American families face significant disparities with regard to income and poverty, as well as some of the worst achievement gaps in the nation.

Additionally, American Indian children, African American children, and children of two or more races are consistently disproportionately represented in out-of-home placement, and research shows out-of-home placement is associated with a greater likelihood of experiencing negative outcomes later in life.

To help narrow income disparities and the achievement gap, children of color must have access to quality early learning opportunities that can improve school readiness.

Equity and Inclusion:

This proposal intends to achieve outcomes that are more equitable for children and families of color and American Indian children and families by increasing access to CCAP for foster care parents and relative caregivers, thereby reducing racial inequity in accessing financial support for child care.

In State Fiscal Year 2021, 60 percent of children served by Basic Sliding Fee program alone were children of color or American Indian children, specifically African American, Asian/Pacific Islander, Hispanic/Latino, multiple races, and American Indian. Of all children served by Basic Sliding Fee, 45 percent were African American. Accordingly, any impact on children and families receiving child care assistance or the providers who serve them is likely to disproportionately affect African American children.

Likewise, Minnesota has significant racial disparities in out-of-home care; African American and American Indian children, and children of two or more races, are disproportionately likely to experience an out-of-home placement.[11] Additionally, through stakeholder engagement, it was reported that many tribes prefer to use transfers of permanent legal and physical custody over adoption, in order to avoid permanently terminating a parent's parental rights.

Currently, adoptive parents receiving Northstar Adoption Assistance are able to receive CCAP. Having disparate access to CCAP, depending on permanency outcome, is an equity issue, particularly considering tribal preference for TPLPC over adoption for many Tribal Nations.

Northstar Care for Children was also touted as a program that ensured equity in benefits so caregivers did not have to decide if they could afford a reduction in benefits in order to adopt or accept a TPLPC of a child in their care. While CCAP is not a Northstar benefit, other programs (such as MFIP) treat NAA and NKA benefits similarly/equitably, for example, MFIP requires households to exclude kids receiving NAA or NKA.

NKA is a benefit program that provides financial assistance and medical assistance to eligible children in foster care whose relative foster parents accept a transfer of permanent legal and physical custody. In March of 2022, 4,442 children received an NKA payment. Of those, 34% were American Indian, 18% were two or more races, and 11% were African American/Black. The addition of NKA families may increase American Indian representation in CCAP.

[11] According to Minnesota's Out-of-home Care and Permanency Report for 2020: "American Indian children were 16.4 times more likely, African American/Black children 2.4 times more likely, and those identified as two or more races were 6.8 times more likely than white children to experience care, based on Minnesota population estimates from 2019."

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

This proposal particularly affects American Indian children and families because many Tribes do not believe in terminating parental rights, so a transfer of permanent legal and physical custody is the preferred permanency option for children in foster care who cannot be reunified with their caregivers. The impact on Tribal members is an equity consideration. This proposal supports relative custodians who have permanent legal and physical custody of children by allowing them to apply for the Child Care Assistance Program.

As noted earlier, the Ombudsperson for American Indian Families also expressed support for CCAP to expand their definition of legal guardian.

Impacts to Counties:
Department CCAP staff and CSP consulted with counties by meeting with financial workers, supervisors, CSP representatives from local agencies and attorneys from Hennepin County, including lobbyists from MACSSA, specifically engaging with them on July 21, August 11, August 19 and August 26 in 2021. Counties broadly supported this proposal and cited its valuable impact on reducing disparities. Additionally, one county has consistently engaged department staff over the past few years in proposing legislation that would allow relative custodians access to CCAP, pointing out equity concerns particularly for American Indian families as well as permanency delays for younger children in foster care, as relatives often must take into consideration their ability to care for children financially as they experience both a reduction in Northstar payments once they become permanent relative custodians and exclusion from other financial benefit programs such as MFIP and CCAP.

Key Themes:

- The number of families served under CCAP would increase, with estimated costs covered by additional funds.
- Counties and tribes may experience higher CCAP caseloads and increased need for coordination.

Additionally, counties will realize a direct cost savings as a result of reduced spending on Northstar child care as families shift to BSF. These savings are estimated to be $771 thousand in FY2024 and $1.6 million in FY2025. These savings are not reflected elsewhere in this proposal because the state or federal government will not recoup them.

IT Costs:
The Minnesota Electronic Child Care Systems, or MEC^2, the automated system that supports the Child Care Assistance Program, will need changes in order to implement this proposal. MN.IT estimates an initial total cost of $162,261 in FY 2024. MN.IT estimates the ongoing maintenance cost at $32,452 in FY's 2025, 2026, and 2027.

Category	***FY 2024***	***FY 2025***	***FY 2026***	***FY 2027***	***FY 2028***	***FY 2029***
Payroll						
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software						

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Training						
Enterprise Services						
Staff costs (MNIT or agency)	162,261	32,452	32,452	32,452		
Total	**162,261**	**32,452**	**32,452**	**32,452**		
MNIT FTEs						
Agency FTEs						

Results:

If this proposal passes, CCAP staff will be able to track how many families meeting these criteria are served annually. The CCAP Family Profile would include the results.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Notes*
Quantity	Number of Foster Care and Kinship families served (by race and ethnicity).	0	0	Foster Care and Kinship Assistance families are not currently served by CCAP.
Anticipated Results	Number of Foster Care and Kinship families served (by race and ethnicity) that are estimated to switch to receiving care from the CCAP Basic Sliding Fee (BSF).	0	709 Northstar Kinship Assistance 462 Northstar Foster Care	After implementing this proposal, an estimated 1,171 additional families could receive care from CCAP BSF.

Expanding access to CCAP to these families reduces the financial burden of being a foster care parent or a relative custodian. The financial burden of child care is significant. For example, a caregiver of three children (aged 1 year, 4 years, and 8 years) in Hennepin County could face $3024 under NKA, and a $2576 monthly shortfall under NFC, using data from the 2021 Market Rate Survey.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			89	12,256	12,345	30,088	30,521	60,609
HCAF					-			-
Federal TANF					-			-
Federal Fund			-	(498)	(498)	(1,126)	(1,165)	(2,291)
Total All Funds			89	11,758	11,847	28,962	29,356	58,318
Fund	**BACT#**	**Description**	**FY24**	**FY25**	**FY24-25**	**FY26**	**FY27**	**FY26-27**
1000	11	Systems(MEC2stateshare@55%)	89	18	107	18	18	36
3000	26	Northstarfederal	-	(498)	(498)	(1,126)	(1,165)	(2,291)
1000	26	Northstarstate	-	(1,060)	(1,060)	(2,395)	(2,477)	(4,873)
1000	42	BasicSlidingFee	-	13,298	13,298	32,465	32,980	65,445
		RequestedFTE's						
Fund	**BACT#**	**Description**	**FY24**	**FY25**	**FY24-25**	**FY26**	**FY27**	**FY26-27**

Statutory Change(s):

Minn. Stat. § 119B.011 (Federal law allows states to define who counts as an eligible applicant.)

Change Item Title: Building Assets for Minnesota Families

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	1,438	2,719	5,219	5,219
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	1,438	2,719	5,219	5,219
FTEs	**2**	**2**	**2**	**2**

Recommendation:

The Governor recommends an investment of $4.2 million in FY 2024-2025 and $10.4 million in FY 2026-2027 from the general fund to increase base funding for the Family Assets for Independence in Minnesota (FAIM) program. State funding for FAIM is currently $325,000 per year, or $650,000 per biennium.

The Governor also recommends amending the Family Assets for Independence in Minnesota statute to:

- Allow Tribal Nations and nonprofits to administer the program with the goal to reach more diverse participants
- Allow participants to contribute to an emergency savings account or college savings account for their children
- Increase the financial match limit to counteract rising costs and support more families in asset acquisition

Rationale/Background:

Family Assets for Independence in Minnesota, commonly known as FAIM, helps working Minnesotans with low incomes increase their savings, build financial assets, and enter the financial mainstream. The program combines matched savings accounts with personal finance education, asset-specific training, and ongoing coaching. This approach helps working families acquire assets, improve their financial capabilities, and increase their economic security. Eligible program participants open an Individual Development Account (IDA), a matched savings account that provides financial incentives to save. Participants receive financial matches at a rate of a 3-to-1 for every dollar of earned income deposited. The matched savings account helps Minnesota's low-wage earners build assets through purchase of a home or automobile, pursuit of higher education, or launching or growing a small business. State funds for this program support the financial match for the IDAs and financial coaching. FAIM is Minnesota's only statewide IDA program and is delivered by a statewide multi-site collaborative of Community Action Agencies, community-based nonprofits, Tribal Nations, and Bremer Bank.

In 2016, Minnesota received a 5-year, $1,000,000 Assets for Independence grant from U.S. Health and Human Services for the FAIM program. This funding ended in April 2021, and the federal program was eliminated.

Proposal:

This proposal invests $4.2 million in FY 2024-2025 and $10.4 million in FY 2026-2027 from the general fund to increase base funding for the FAIM program. It includes 2 FTEs, a grant manager and a supervisor to manage the expanded work of the Community Action team. This proposal also amends the FAIM statute to:

- Allow Tribal Nations to administer the program

- Allow other nonprofit organizations to administer the program
- Allow participants to contribute to a Minnesota 529 college savings plan for their children
- Allow participants to contribute to an emergency savings account for unexpected expenses like car repairs or medical bills; and
- Increase the financial match limit from $6,000 to $12,000.

This investment in FAIM will benefit a larger and more diverse group of FAIM account holders, increase its capacity to serve up to 500 additional families per year, and allow for much-needed evaluation and redesign opportunities. This proposal expands the FAIM program, which helps people achieve wealth through asset acquisition, by including saving for college for their children. Currently, the program focuses on saving for a home, small business, a vehicle, or education expenses.

Impact on Children and Families:

In families where assets are owned, children do better in school, voting participation increases, and family stability improves.[1] Reliance on public assistance decreases as families use their assets to access higher education and better jobs, reduce their housing costs through ownership, and create their own job opportunities through entrepreneurship.[2] Research also shows that as little as $500 in college savings can make a difference in encouraging higher education for children from families with low incomes.[3] Increasing state funding for FAIM will benefit working Minnesotans with low incomes that want to increase their savings and build financial assets.

Equity and Inclusion:

Income and asset ownership disparities for people of color and American Indians are significant. The FAIM program specifically addresses asset attainment. Increasing state funding for this program will reduce asset ownership disparities for people of color and American Indians. Research from the IDA field suggests that people with very limited incomes can and do save money and accumulate assets when given incentives, financial education, and institutional supports.

To achieve long-term economic security, working individuals with low incomes and those leaving public assistance need opportunities to build savings, plan for emergencies, and acquire financial assets. The gap in wealth and financial assets between people with low incomes and people with higher incomes is significantly larger than the income gap itself. The wealth and financial assets gap also is disproportionately higher for communities of color and American Indian communities. Increasing state funding for this program will help close the financial asset gap for people of color and American Indians.

The race/ethnicity of FAIM participants: 50% white, 34% Black or African American, 4% Asian, 2% American Indian, 6% multiple races, and 4% declined to identify (20% of people identified as Latino/Hispanic of any race).

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

This proposal amends the Family Assets for Independence in Minnesota statute to allow Tribal Nations to administer the program. This proposal was presented to all Tribal Nations at the Tribal Summit in 2022.

[1] Washington University in St Louis, Center for Social Development, 2020
[2] Washington University in St Louis, Center for Social Development, 2020
[3] Small-Dollar Children's Savings Accounts, Income, and College Outcomes, Washington University in St Louis, Center for Social Development, 2013

The poverty rate for American Indians in Minnesota is more than 4 times higher than the poverty rate for white Minnesotans.[4] Unemployment rates for American Indian workers were more than 3 times higher than white workers even before the COVID-19 pandemic.[5]

Impacts to Counties:
This proposal does not impact counties financially. FAIM is delivered by a statewide multi-site collaborative of Community Action Agencies, community-based nonprofits, Tribal Nations, and Bremer Bank.

IT Costs:
Not applicable.

Results:
As of April 2022, 1,114 Minnesotans had participated in FAIM, collectively saving $4.92 million. FAIM delivers a strong return on investment for the public dollars invested. Purchases boost local economies through increased home ownership, property taxes, newly created jobs, small business purchases, and increased professional skills.

FAIM Post-Secondary Education

- 40% of respondents indicated that their employment had improved since completing their education.[6]
- 57% indicated their incomes had increased.[6]

FAIM Home Ownership

- 97% still owned their own home.[6]
- 39% had no debt other than their mortgage.[6]

FAIM Small Business

- 89% of surveyed FAIM-sponsored businesses were still in operation more than two years after opening compared to a national average of 44%.[6]
- 65% of businesses achieved an increase in their sales and income after applying their FAIM matched savings to improve their businesses.[6]
- Of the 130 small business accountholders responding, the total estimated revenue was $4.64 million per year.[6]

This proposal would increase the amount of FAIM clients by a significant amount - over 10 times the current number of enrolled clients - and expand asset types to give clients more choice over their short and long-term asset goals.

Evidenced Based Practice	Source
Individual development accounts (IDAs) help low-income families save by matching their personal savings for specific investments, such as a first home, business capitalization, or higher education and training.	Source: OPRE, https://www.urban.org/sites/default/files/publication/101287/from-savings-to-ownership.pdf

[4] Kaiser Family Foundation estimates based on the Census Bureau's American Community Survey, 2008-2018
[5] Minnesota Department of Employment and Economic Development, 2016
[6] Minnesota Community Action Annual Report, 2019

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 27-28
General Fund			1,438	2,719	4,157	5,219	5,219	10,438
HCAF					-			-
Federal TANF					-			-
Other Fund					-			-
Total All Funds			1,438	2,719	4,157	5,219	5,219	10,438
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 27-28**
General Fund	47	Children's Services Grants	1,250	2,500	3,750	5,000	5,000	10,000
General Fund	12	Children and Families Admin (2 FTEs)	277	322	599	322	322	644
General Fund	REV1	FFP @ 32%	(89)	(103)	(191)	(103)	(103)	(206)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 27-28**
			2	2	2	2	2	2

Statutory Change(s):

Minn. Stat. § 256E.35

Change Item Title: Medical Assistance for Former Foster Care Youth from Other States

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	1,368	563	563	563
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	1,368	563	563	563
FTEs	**3.5**	**3.5**	**3.5**	**3.5**

Recommendation:

The Governor recommends complying with federal law by extending Medical Assistance to Minnesotans who were formerly in foster care and enrolled in Medicaid in another state on their 18th birthday. This proposal would require an investment of $1,932,000 in the FY2024-2025 biennium and $1,126,000 in the FY2026-2027 biennium.

Rationale/Background:

The Affordable Care Act requires states to provide Medicaid to youth ages 18-26 who were in foster care on their 18th birthday and were enrolled in Medicaid when they left foster care. Minnesota implemented this coverage group in Medical Assistance, Minnesota's Medicaid program, effective January 1, 2014. In FY 2020, there were approximately 750 former foster care youth enrolled in Medical Assistance in an average month.

On October 24, 2018, the Substance-Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act became federal law.[1] It requires states to now provide coverage for former foster care youth who were in foster care in any state and enrolled in that state's Medical Assistance program when they left foster care. This provision of the SUPPORT Act is effective January 1, 2023.

Proposal:

This proposal amends state law to comply with the SUPPORT Act regarding Medical Assistance for former foster care youth. Effective January 1, 2023, a Minnesotan who was in foster care on their 18th birthday and receiving Medicaid when their foster care ended in any state will qualify for Medical Assistance as a former foster care youth until age 26.

In addition, because the SUPPORT Act conditions the new requirements for this population on whether an individual turned age 18 prior to, or on and after January 1, 2023, the Department will seek an amendment to our existing 1115 waiver, to simplify the eligibility determination by applying the new rules regardless of when a former foster care youth turned age 18.

This proposal will benefit former foster care youth in the following ways:

1) Youth who move to MN from other states will now qualify for MA under the former foster care youth eligibility group, as required under Section 1002 of the SUPPORT Act, and;

[1] Substance-Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, Public Law 115-271, Sec. 1002, October 24, 2018

2) All youth formerly in foster care (from MN or from other states who move to MN) will qualify for the former foster care youth eligibility group without an income test, once foster care status is verified, which will streamline applications and renewals for this population, and;
3) Changes to the MA eligibility rules will prevent delays in access to healthcare for this vulnerable population, as individuals will no longer need to be determined ineligible for other MA eligibility groups prior to being determined eligible for the Former Foster Care Youth eligibility group, in alignment with federal requirements.

DHS requests 3.5 FTEs to implement and support this change ongoing:

- 1 FTE will verify former foster care status for applicants and enrollees statewide through MN social service IT systems and by contacting social service agency officials in other states.
- 1 FTE will serve as the eligibility policy expert resource, conduct research, develop, implement, support and maintain eligibility policies for former foster care youth, explore best practices with colleagues in other states and engage stakeholders to ensure foster care children attain and maintain health care coverage while in placement and to age 26. This FTE will draft and review enrollee and worker facing communications, present to internal and external groups, and provide up-to-date policy interpretations.
- 1 FTE will produce financial reporting necessary to develop and maintain an 1115 demonstration waiver.
- 0.5 FTE will develop an evaluation plan and analyze outcomes specific to newly-covered former foster care youth.

Increased program costs are indeterminable at this time as no data exists to identify how many former foster care youth from other states would seek eligibility in Minnesota based on this change. However, increased enrollment is likely to be minimal, since the population is small, and many former foster care youth from others states who apply for health care in Minnesota prior to this change likely qualify for Medical Assistance under another existing eligibility group.

Impact on Children and Families:

This proposal helps close the opportunity gap and achieve the administration's priorities for children and families by ensuring that former foster care youth are guaranteed access to health care coverage regardless of where they lived before moving to Minnesota. Former foster care youth frequently experience adverse childhood experiences that are linked to poor physical health and lifetime health problems, including diabetes, heart disease, cancer, and stroke.[2] Studies also show youth exiting the foster care system disproportionately face a lack of stable housing and unemployment than their cohorts who have not interacted with the foster care system.[3]

Equity and Inclusion:

This proposal helps improve access to health care for former foster care youth by reducing barriers to Medical Assistance coverage when they move across state lines. Former foster care youth are more likely to be uninsured, have complex health issues, and face social and economic crises that compound health needs, than those who have not interacted with the foster care system.[4] Younger children, children from rural counties, and children of color and American Indian descent are disproportionally represented in the foster care system in Minnesota.[5] In Minnesota foster care:

- Children of color are overrepresented compared to the number in the general population; American Indian children are around 18 times more likely than their white counterparts to experience out-of-home

[2] Medicaid and CHIP Learning Collaborative, CMS All-State SOTA Call: Ensuring Access to Medicaid Coverage for Former Foster Care Youth, slide 4, June 2017.
[3] Older Youth Housing, Financial Literacy and Other Supports, National Conference of State Legislatures, April 3, 2020
[4] Medicaid and CHIP Learning Collaborative, CMS All-State SOTA Call: Ensuring Access to Medicaid Coverage for Former Foster Care Youth, slide 4, June 2017.
[5] Foster care: Temporary Out-of-Home Care for Children, Minnesota Department of Human Services, April 2020

care; those of two or more races are six times more likely; and African American or Black children three times more likely.[6]

- Children under age two and those between the ages 15 and 17 are the most likely age groups to experience out-of-home care.[7]
- Not all children eventually get adopted. In 2018, 87 youth who were state wards aged out before being adopted. Of those who aged out, 28 (32%) continued in care after turning 18 through extended foster care. [8]

Youth in foster care have an uninsurance rate of 2-5%, while former foster care youth at age 19 have an uninsurance rate of 16-35%, which shows how important it is to connect this vulnerable population with health care.[9]

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

This proposal is not anticipated to significantly impact tribes. However, it will advance tribal equity efforts by connecting American Indian children under age 26 who are former foster care youth to health care when they move to Minnesota after aging out of the foster care system.

Impacts to Counties:
This proposal is not anticipated to significantly impact counties. This basis of Medical Assistance eligibility already exists in Minnesota, and counties do not need to take any special actions when determining eligibility for this group. However, due to changes in verification rules, counties will need to notify DHS when someone is determined eligible for the Former Foster Care basis, so that a DHS employee can conduct the verification for both in-state and out-of-state foster care status.

IT Costs
This proposal requests funding for systems changes needed to update the Minnesota Eligibility Technology System (METS) online application to gather information to identify applicants who were enrolled in foster care and Medicaid in states other than Minnesota and aged out on and after January 1, 2023, apply verification rules, and correctly determine eligibility. MNIT estimates that it will cost a total $2,797,045 to implement this proposal in METS. The development would take approximately 9 months to complete.

Results:
The Department of Human Services expects this proposal will result in increased access to health care services for former foster care youth who have moved to Minnesota from another state. Current Medical Assistance enrollment of former foster care youth averages about 750 monthly enrollees.

[6] *Id.* at pg. 3.
[7] Minnesota Department of Human Services, Minnesota's Out-of-Home Care and Permanency Report 2018, pg. 6, December 2019.
[8] *Id.* at pg. 39.
[9] Medicaid and CHIP Learning Collaborative, CMS All-State SOTA Call: Ensuring Access to Medicaid Coverage for Former Foster Care Youth, slide 4, June 2017.

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	**Enrollment Increase:** Data will be collected from applications regarding the amount of people who indicate they were in foster care on their 18th birthday and enrolled in Medicaid when they aged out of foster care in another state.	N/A - Currently, former foster care youth from other states who move to Minnesota do not meet the eligibility criteria for this basis of eligibility, so this data is not collected from applicants.				January 1, 2024 (quantity can be measured one year following the January 1, 2023 effective date).
Quality	**Access**: Increased access to health care services for former foster care youth under age 26 who have moved from another state to make Minnesota their home.					January 1, 2024 (quantity can be measured one year following the January 1, 2023) effective date).
Results	**Enrollment Increase:** Data will be collected on the amount of people who are newly eligible for the Former Foster Care basis due to being in foster care on their 18th birthday and enrolled in Medicaid when they aged out of foster in another state. The number of potential Former Foster Care enrollees who move	N/A - Currently, former foster care youth who move to Minnesota do not meet the eligibility criteria for this eligibility category, so data does not exist.				January 1, 2024 (quantity can be measured one year following the January 1, 2023 effective date).

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
	to Minnesota after 2023 and apply, meet the eligibility criteria, and enroll in MA cannot be estimated at this time due to unavailability of relevant data.					

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			1,368	563	1,931	563	563	1,126
HCAF								
Federal TANF								
Other Fund								
Total All Funds			1,368	563	1,931	563	563	1,126
Fund	**BACT#**	**Description**	**FY24**	**FY25**	**FY24-25**	**FY26**	**FY27**	**FY26-27**
GF	13	HCAAdmin-FTEs(2.5,2.5,2.5,2.5)	316	362	678	362	362	724
GF	11	OPSAdmin-FTEs(1,1,1,1)	133	153	286	153	153	306
GF	REV1	FFP@32%	(144)	(165)	(308)	(165)	(165)	(330)
GF	11	StateShareofSystemsCosts	1,063	213	1,276	213	213	426
		RequestedFTE's						
Fund	**BACT#**	**Description**	**FY24**	**FY25**	**FY24-25**	**FY26**	**FY27**	**FY26-27**
GF	13	HCAAdmin-FTEs(2.5,2.5,2.5,2.5)	2.5	2.5		2.5	2.5	
GF	11	OPSAdmin-FTEs(1,1,1,1)	1	1		1	1	

Statutory Change(s):

Minn. Stat. 256B.055, subd. 17

Change Item Title: Child Support Improvements and Investments

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	218	268	110	110
Revenues	0	0	0	0
Other Funds – Special Revenue				
Expenditures	64	32	32	32
Revenues	64	32	32	32
Net Fiscal Impact = (Expenditures – Revenues)	218	268	110	110
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends an investment of $390,000 in the FY24-25 biennium and $78,000 per year ongoing for updates to child support guidelines, enforcement, and compliance with federal regulation from the state general fund. Additionally, $96,000 in FY24-25 and $32,000 ongoing is requested to transfer to the special revenue to support the child support division's compliance with federal review. The changes will make necessary adjustments to relieve the negative impacts of child support arrears and help prevent them in the future.

Rationale/Background:

Guidelines Changes

Over the last decade, child support arrears have nearly doubled in Minnesota, causing negative consequences for payers, with the disproportionate impact falling on African American and American Indian payers. One reason for increased child support arrears is orders that are set too high for the payer's financial circumstances. Minnesota's child support guidelines are used by courts to set child support obligations. Special provisions apply to parents who are not working or make very little money. These provisions include attributing "potential" income to a parent when calculating support even if the parent does not have income,[1] and requiring the parent to pay a minimum order.[2] This ensures that even the very lowest income parents will have an obligation set. Minnesota law allows the court to set a $0 order when a parent is unable to pay, but the standard for inability to pay is difficult to meet. For payers receiving assistance from the Minnesota Family Investment Program (MFIP), General Assistance (GA), or Supplemental Security Income (SSI), child support obligations will likely result in arrears, causing harm to the payer while not helping the child. Those who have suddenly become disabled can be left with significant arrears accrual before their disability benefits are approved. A county/state workgroup has made recommendations, reflected in this proposal, on areas of the guidelines that affect especially vulnerable payers who are unlikely to be able to pay.

Driver's License Suspension

Many stakeholder organizations have raised concerns with the use of driver's license suspension to remedy nonpayment of child support.[3] Federal law requires states to have a process for suspending driver's licenses for nonpayment of child support, but states are given discretion to determine when and how to use this enforcement remedy.[4] License suspension is a valuable tool when a child support payer is willfully refusing payment. For those

[1] See: Minn. Stat. § 518A.32
[2] See: Minn. Stat. §518A.42, subd. 2
[3] See: Minn. Stat. 518A.65
[4] 45 C.F.R. §303.31(a)(2)

unable to pay, it creates an additional barrier to employment and can get in the way of co-parenting. Stakeholders have overwhelmingly requested a reduction in use of this remedy. To respond, the Department of Human Services (department), along with participating counties and the federal Office of Child Support Enforcement, created a procedural justice informed pilot project to rework the driver's license suspension process. County participants from that group worked with the state to create a legislative proposal intended to refine the remedy so it applies in cases where it is likely to be successful and will not apply in cases where it will only have a negative impact on families. Final results of the pilot will not be received until January, but this proposal represents common sense changes based on what county pilot participants learned.

Medical Support Reforms

When child support is determined in Minnesota, there are three types of support: basic support, childcare support, and medical support. Each parent with income available for support is expected to contribute financially to their child's basic needs, childcare expenses, and medical insurance/uninsured medical costs based upon their proportional share of the parents' combined incomes.[5] In 2016 new federal regulations were implemented that allow states more flexibility in how they set medical support obligations.[6] A state/county workgroup met to redraft the medical support statutes to be responsive to both the new federal rules and the changing environment of medical support as coverage has become more expensive and changes to medical assistance have made more families eligible for public coverage.

Quadrennial Review

The quadrennial review of the child support guidelines, due every 4 years under federal law,[7] will be due again in 2026. Updated federal regulations have made the report more labor intensive than previous years and require the department to obtain the assistance of an economist to provide analysis on new required data points. The federal changes require the department to obtain public input on the guidelines and any potential proposed changes to them. To do this work, the department requires resources for public engagement activities. Additionally, legislation enacted during the 2022 session added a January 1, 2032 sunset date to the quadrennial review, which is not compliant with federal law requiring this report every four year.

Proposal:

Guidelines Changes

To address unpayable child support orders, this proposal would clarify that parents in certain situations should not have income imputed to them and should not be subject to a minimum order. This will make it easier for a court to set a $0 order when the payer has no ability to pay, thus reducing arrears balances for the most vulnerable. For those who have benefits approved following disability, the proposal will allow payment of child support arrears by the derivative benefits that flow to the child. Specifically, the proposal does the following:

- Prohibits courts from assigning the child support payer with a minimum order when the payer is on MFIP or GA.
- Exempts all recipients of MFIP from the application of potential income when determining child support. Currently, the statute exempts recipients of TANF only. This proposal would also allow those who do not receive cash and those who receive state funded MFIP to qualify for the exemption.
- Exempts recipients of SSI/GA from the application of potential income when determining child support.
- Allows lump sum derivative payments to satisfy arrears that accrued during the eligibility period for Social Security or VA benefits (allowing payments from Social Security or VA to pay for child support that was owed during the period the benefits are for).

[5] See: Minn. Stat. 518A.34

[6] https://www.acf.hhs.gov/sites/default/files/documents/ocse/fem_final_rule_summary.pdf

[7] 45 C.F.R. § 302.56(h)

- Subtracts derivative benefits prior to application of the self-support reserve when determining the payer's ability to pay.[8]

The cost for these provisions is $396,099 in the FY 2024–2025 biennium, and $79,220 per year ongoing for changes to PRISM, the state's automated child support IT system, and the Minnesota Child Support Web Calculator. ***Effective date***: January 1, 2025.

Changes Related to Driver's License Suspension

This proposal would make several changes to the way that child support arrears lead to driver's license suspensions. Specifically, the proposed legislation would:

- Only apply the remedy in cases where the parent has a valid driver's license. Currently the remedy may apply even when the payer does not have a license, including when a license was suspended for another reason. In these cases, a suspension for nonpayment of child support is unlikely to result in child support payments. Despite the low likelihood of coercing a payment, there remains a high likelihood of harm to the obligor from the suspension. Multiple suspension reasons can be confusing and overwhelming, creating mounting barriers to obtaining the license, reducing the likelihood of them resolving the reasons and increasing the likelihood that the parent will drive without a license.
- Provide funding to update PRISM so that cases will be excluded when the last known address of the payer is known to be an address that is no longer applicable. It is unfair to the parent and will not likely result in child support payments if the driver's license suspension remedy applies without actual notice to the parent.
- Exclude payers from the remedy when they are receiving MFIP, GA, or Supplemental Security Income (SSI) and when participants are recently released from incarceration.[9] These payers are unlikely to be able to make payments, so suspending their driver's license will not incentivize child support payments. Rather, this remedy is more likely to create barriers to employment, future payment of child support, and co-parenting their children.
- Allow child support officers and courts more discretion in whether to apply the remedy and whether to end suspension when it is in place. This would allow more licenses to be maintained or returned based on an assessment of the facts and whether the suspension is more likely to result in child support payments or cause harm to the family.
- The cost for these provisions is $461,835 in the FY2024–2025 biennium and $92,367 per year ongoing to update PRISM. ***Effective date***: July 1, 2023 for provisions relating to increased discretion, and July 1, 2026 for provisions related to limiting eligible cases that require PRISM updates.

Medical Support Reforms

These provisions are intended to create efficiencies in the child support system and update the guidelines so they are more in line with the changing health insurance landscape in Minnesota. Changes would be effective July 1, 2024.

- *Definition of Health Insurance.* A change to federal rule expands the definition of "health care coverage" for child support purposes to include public coverage.[10] Minnesota law currently excludes public coverage from its definition of "health care coverage" when determining medical support for child support purposes.[11] To conform to federal law, this proposal amends the definition of "health care coverage" in Minnesota law to include public health care coverage.
- *Public Coverage Presumed Appropriate.* When determining medical support, if a child is not already covered on a private insurance policy, the court must consider what health care coverage is available to

[8] The self support reserve is an amount subtracted from the child support payer's income when calculating child support. The self support reserve is equal to 120 percent of the federal poverty guidelines for one person. See: Minn. Stat. § 518A.42, subd. 1(b)

[9] The proposed language allows the court or child support agency to decline to suspend a license for up to six months after incarceration or inpatient treatment.

[10] See: 45 C.F.R. § 303.31(a)(2)

[11] See: Minn. Stat. § 518A.41 , subd. 1(a)

the parties for their children and order coverage if the court finds it is "appropriate."[12] This proposal would deem public coverage "appropriate" if a child is already enrolled in and remains eligible for Medical Assistance when a court is making medical support determinations. Under this change, a court could order that Medical Assistance continue without making further findings. This change would eliminate the inefficient and time-consuming process for the court to review different insurance options when a child is already receiving Medical Assistance and remains eligible.

- *Administrative Suspension of Medical Support.* When a parent who is paying basic support is ordered to cover the child on their health insurance, the parent receiving support is ordered to pay medical support to the parent paying basic child support. To avoid the absurdity of both parents paying the other, statute allows the recipient's medical obligation to offset the payer's basic support obligation.[13] Therefore, the parent paying support would pay their basic support, less the medical support owed by the parent receiving the basic support. Should a parent ordered to pay basic support and to provide medical insurance fail to keep the child insured, the offset may be stopped administratively, allowing the child support agency to collect the entire basic support amount. This effectively ceases enforcement of the medical support obligation.

  There is no similar administrative procedure to stop collection of medical support when a parent receiving child support is also ordered to provide medical insurance for the child. This proposal would allow collection of the medical support obligation from the parent paying support to be administratively suspended by the child support agency. This proposal creates parity between parents as this suspension of enforcement is already allowed when the other parent owes the medical support obligation.

- *Determination of Obligated Parent's Eligibility for Public Coverage.* When a child receives medical assistance, the parent paying child support may also be required to pay a contribution toward the cost of public medical coverage.[14] Currently, statute excludes child support payers from this requirement if they are eligible for public medical coverage or receiving public assistance.[15]

  Local child support agencies do not have access to all information needed to determine whether a payer is eligible for public medical coverage. For example, a spouse's income may be needed to determine eligibility for medical coverage, but that income is not counted in a child support case. Absent an ability to determine eligibility, child support calculators compare a child support payer's Parental Income for Child Support against the medical assistance eligibility standard for a household of one. This arbitrary standard may leave out payers who are eligible for or receiving medical assistance because a household size of one is not accurate to their circumstances.

  This proposal provides that a child support payer with income below 200% of the federal poverty guideline, currently $27,080/year, would not be ordered to pay a contribution toward a joint child's public medical coverage. This helps ensure payers are not improperly charged for public medical coverage and avoids the inefficient process of collecting unnecessary information.

- *Define "Reasonable in Cost."* Federal child support rules require state guidelines to define what is "reasonable in cost" for medical coverage when determining child support obligations.[16] States may use the definition in the federal rules or a reasonable alternative. [17] The department has long provided

[12] See: Minn. Stat. § 518A.41, subd. 4
[13] See: Minn. Stat. 518A.41, subd. 16
[14] See: Minn. Stat. § 518A.41, subd. 4 and 14
[15] See: Minn. Stat. § 518A. 41, subd. 4(f)(3)
[16] See: 45 CFR 303.31
[17] This definition was in a prior version of federal rule. The current definition that states can, but are not required to, use is: "Cash medical support or the cost of health insurance is considered reasonable in cost if the cost to the parent responsible for providing medical support

guidance to local child support agencies that defined the cost of health care coverage as reasonable if the marginal cost of adding the child to a parent's individual health insurance coverage does not exceed 5% of the parties' combined parental income for child support (PICS). However, department policy guidance to local agencies does not govern private child support cases. This means there is not uniformity statewide, and Minnesota is not in full compliance with federal requirements. This proposal codifies department guidance creating a statewide definition of "reasonable in cost" when determining medical support, with additional discretion to consider high deductibles and costs to cover the parent if that is a prerequisite to covering the child.

The cost for these provisions is $289,674 in the FY2024–2025 biennium and $57,935 per year ongoing to update PRISM. ***Effective date:*** January 1, 2025.

Quadrennial Review

States are required to complete a review of their child support guidelines every four years.[18] Federal rule changes made in 2016 require states to analyze additional economic information and authentically engage with the public to obtain input on child support guidelines. For the 2022 review, the Child Support Division was able to leverage the work of the Child Support Task Force and the work of its economist to complete the quadrennial review. In 2026, the Division will not be able to complete the work absent additional resources. An appropriation in 2024 is imperative to ensure the department has sufficient time to contract with an economist and complete the work for the 2026 review, keeping Minnesota in federal compliance. This proposal provides the agency with the necessary resources to prepare a federally compliant report in 2026 and ongoing. Specifically, new federal requirements require:

- Analysis of labor market data (such as unemployment rates, employment rates, hours worked, and earnings) by occupation and skill-level for the State and local job markets, the impact of guidelines policies and amounts on custodial and noncustodial parents who have family incomes below 200 percent of the Federal poverty level, and factors that influence employment rates among noncustodial parents and compliance with child support orders.
- Analysis of the rates of default and imputed child support orders and orders determined using the state's low-income adjustment. The analysis must include a comparison of payments on child support orders by case characteristics.
- The department to provide a meaningful opportunity for public input, including input from low-income child support payers and recipients, and local child support agencies.

Most of the requested appropriation would be used to hire an economist to assist DHS with the newly required data analysis. Other funds would pay for the costs associated with accessible public meetings, including facilitation services, captioning, and translation. Because the report is due every four years, a special revenue fund would be established for all activities related to the report. This will enable the department to enter into a contract with an economist every four years and allow the department to schedule public meetings throughout the report period.

The cost for these provisions is $64,000 in the FY2024 and $32,000 per year ongoing. These funds will transfer into a special revenue fund to ensure that the funds are available for expenditure every four years. The 2024 cost is slightly higher to ensure that the department has sufficient funds for the 2026 review. ***Effective date***: July 1, 2023.

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does not exceed five percent of his or her gross income, or at state option a reasonable alternative income-based numeric standard defined in state law." The department has concerns that the federal definition will result in higher numbers of uninsured children in Minnesota.

[18] 45 C.F.R. § 302.56(h)

Impact on Children and Families:

When child support, including medical support, is set in amounts that parents can pay, child support reduces child poverty, promotes parental responsibility and improves children's educational outcomes.[19] However, if support is set in an amount the parent cannot pay, the child does not receive the support and the parent who pays support accrues child support debts. Child support debts trigger enforcement remedies and can negatively affect the relationship between parents.

The driver's license suspension remedy can create barriers to employment and exercising parenting time with the child. Ensuring health care coverage for children is affordable increases the likelihood that a child will have medical coverage. When children have medical insurance, their parents can bring the child to well-child visits, obtain routine vaccinations, and not choose between providing food and housing or paying hospital bills should a child have a chronic illness or suffer an injury in need of emergency care.

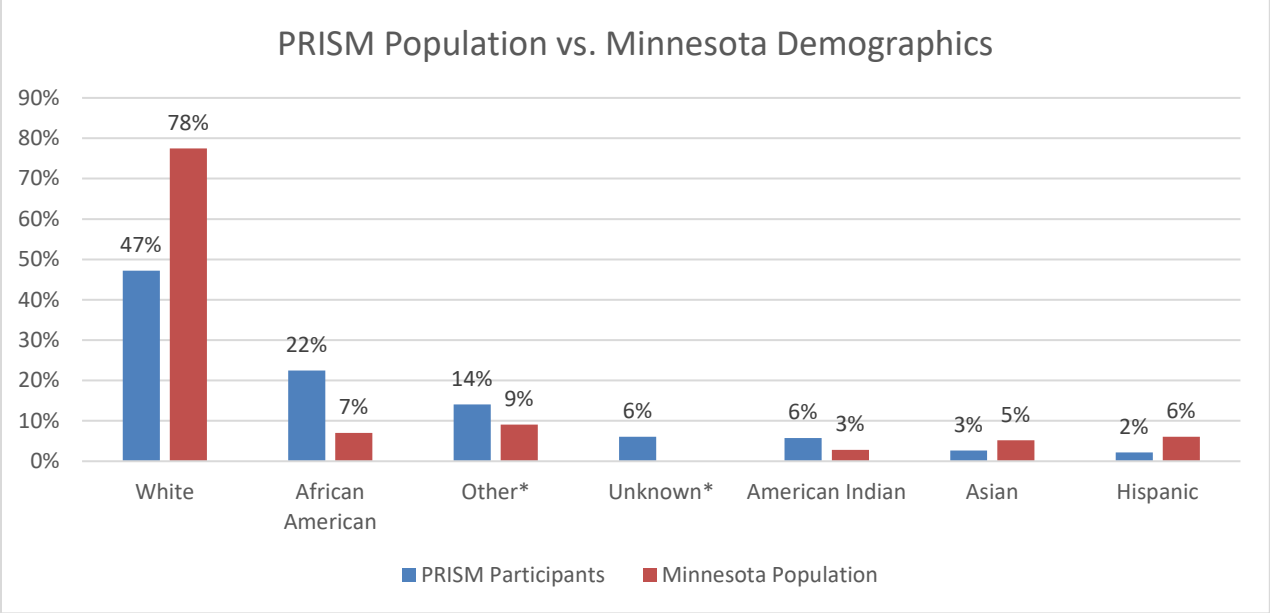
Providing resources for the department to complete the quadrennial review in compliance with federal rules will enable the state to carefully analyze child support guidelines and the impact they have on the ability of parents to support themselves and their children. The quadrennial review will help the state ensure "right sized orders" for child support. Orders that are right sized can be paid in full and on time to provide the financial support the child needs and ensure that the child support orders do not result in unnecessary and harmful debt.

Equity and Inclusion:

Black, Indigenous and other people of color disproportionately experience poverty in Minnesota, with African Americans and American Indians experiencing poverty at a rate four times higher than that for white Minnesotans.[20] Indigenous and African American families also have the lowest median incomes in Minnesota.[21] Racial disparities in income and employment result in a disproportionate number of African American and Indigenous parents participating in the MFIP program.[22] In Minnesota, 18% of American Indians live with a disability, higher than all other racial or ethnic groups in the state[23]

Reflecting these persistent disparities, African American and Indigenous parents are overrepresented in the IV-D child support system. These populations are also most likely to be in arrears, with African American child support payers owing 33% of all arrears tracked in PRISM while representing 22% of the caseload. This table illustrates the disproportionate overrepresentation of African American and Indigenous child support payers in the IV-D system:

[19] https://www.ncsl.org/research/human-services/how-child-support-affects-low-income-fathers.aspx
[20] Minnesota Department of Health, People in Poverty in Minnesota, 2019.
[21] https://www.mncompass.org/disparities/race#1-9529-g
[22] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4219U-ENG
[23] https://www.mncompass.org/topics/demographics/disability



Provisions in this proposal can help reduce disparities based upon race and economic status that are made worse by child support policies. Specifically, this proposal will:

- Prevent the accrual of child support arrears for the most economically vulnerable child support payers.
- Address the potential damage caused by driver's license suspension as a remedy for child support arrears.
- Better ensure child support orders are right sized by limiting the amount of child support obligations ordered for those who are most likely unable to pay.

Additionally, ensuring Minnesota's quadrennial review complies with the new federal emphasis on factors related to income and employment will likely highlight the interaction between the child support guidelines and well-known racial disparities in education,[24] unemployment,[25] and participation in certain industries,[26] as well as disparities in employment tied to disability status[27] and former incarceration.[28] The more detailed analysis of the impact child support guideline policies and order amounts have on child support payers and recipients, particularly those who have family incomes below 200% of the federal poverty level, will help the state better ensure child support orders are not causing harm to payers experiencing poverty as well as to develop equitable child support policies.

In addition, funding for community engagement will not only allow the department to comply with federal requirements, but it will also ensure that Minnesotans impacted by the child support guidelines have their voices heard by policymakers.

[24] The share of Minnesotans without a diploma are highest for immigrants and Native Americans. https://mn.gov/admin/assets/the-economic-status-of-minnesotans-chartbook-msdc-jan2016-post_tcm36-219454.pdf. Asian and to a lesser extent white Minnesotans are most likely to have a bachelors degree. https://mn.gov/admin/assets/MNSDC_EconStatus_2018Report_FNL_Access.pdf_tcm36-362054.pdf

[25] Unemployment rates for American Indian, African American, and Latinx workers are 2-3 times higher than white workers. Minnesota Department of Employment and Economic Development, How Does Minnesota Unemployment Compare, 2015.

[26] Minority populations, including African American, Indigenous, and Hispanic populations are more likely to participate in certain industries, in particular lower-wage jobs in the health care industry. https://mn.gov/deed/assets/041018_tc_disparities_tcm1045-341196.pdf

[27] Disabled Minnesotans are less likely to be employed and those who are employed are more likely to be employed part-time. https://www.disability.state.mn.us/information-and-assistance/employment-fact-sheet/

[28] https://mn.gov/deed/newscenter/publications/trends/september-2015/prisoners-dilemma.jsp

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
The changes to child support guidelines in this proposal originated with counties and will result in processes that are more efficient and pleadings when establishing or modifying child support. Limiting the number of cases in which county agencies and courts must discover and assess all available medical coverage, as currently required, will reduce local agency work when determining medical support in some cases. Counties currently follow state guidance related to the affordability of medical coverage. Because this proposal simply codifies that guidance, that provision will not affect counties. Finally, by treating parents responsible for paying basic support or receiving basic support differently when a parent stops providing court-ordered medical coverage, counties report child support payers believe the system is biased against them. By allowing administrative action to stop collection of medical support or eliminate the offset of basic support when a parent fails to carry coverage as ordered, parents will be treated equally in state law.

The changes to the driver's license suspension remedy will be unlikely to have measurable impacts for county workers. The legislation will shift the process towards one that is more manual, which tends to increase work for county child support officers. However, the changes will likewise eliminate some cases from the process altogether, by requiring a known address and a valid driver's license be in place.

The counties will not be directly impacted by the quadrennial review, though they will benefit from the strength of the research it contains.

IT Costs:

Category	***FY 2024***	***FY 2025***	***FY 2026***	***FY 2027***	***FY 2028***	***FY 2029***
Payroll						
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)	452	608	212	212	212	212
Total	**452**	**695**	**229**	**229**	**229**	**229**
MNIT FTEs						
Agency FTEs						

Results:

Type of Measure	*Name of Measure*	*FFY 2021*	*FFY 2020*	*FFY 2019*
Quantity	Collection on current support	75.75%	75.41%	74.40%
Quantity	Collection on arrears	72.30%	79.65%	72.91%
Quantity	Program cost effectiveness	$3.09	$3.26	$3.14

In general, changes to the guidelines for lower income payers and some of the medical support provisions contribute to "right sized orders." Orders that can be paid completely and reliably while allowing the paying parent to support themselves and their child when in their care are right sized. In some cases, a right sized order may be a $0 order. This proposal will result in more right sized orders, which will improve several performance measures.

Collections on current support. Provisions related to imputed income, exemptions from the minimum order, setting clear affordability limits for medical coverage, allowing presumptive medical assistance, and not ordering reimbursement for medical assistance for payers earning under 200% of the federal poverty level will reduce the amount of child support due in Minnesota, as well as reduce the amount of child support that is not collected. Thus, Minnesota's IV-D agencies would collect a higher percentage of child support owed.

Collection on arrears. Provisions helping ensure child support orders are right sized will better ensure child support payers can pay their child support obligations and reduce any existing arrears. The provision in this proposal related to lump sum payments for derivative benefits would, in some cases, result in a significant payment toward reducing a payer's child support arrears. Accordingly, this proposal may result in improvements in the ratio of payments on arrears to total of arrears owed.

Program cost effectiveness. In FFY 2021, for every dollar local child support agencies spent on child support enforcement, they collected $3.09. Some of the provisions in this proposal will increase local agency effectiveness. For example, a presumption of a $0 order for cases where a payer is on GA, MFIP, or SSI will reduce the need for complicated court pleadings and result in fewer legal disputes. Allowing medical assistance to be presumed appropriate coverage will save county workers time, allowing them to focus on collection efforts that are more productive. Accordingly, this proposal may result in improvements to the ratio of dollars expended for collecting child support to the amount of child support collected.

Driver's License suspension reform. Anecdotal evidence from county child support workers indicates that the possibility of driver's license suspension can compel payment compliance from payers who do have the ability to pay choose not to pay. However, there is little evidence in Minnesota or nationwide that systemic application of a driver's license suspension improves child support performance overall. Data in this area is nearly impossible to capture because it is difficult to measure whether a payment that was received was in response to license suspension. For this reason, it is not anticipated that the program can measure success based on standard federal child support performance measures. However, the very high rate of cases in PRISM with an active driver's license suspension indicates that for many people, this enforcement remedy does not work because they are unable to pay their full child support obligation, not choosing not to pay. Nearly 20% of payers in the PRISM computer system have an active driver's license suspension. If the remedy were effective, many more of these payers would have responded, paid their arrears, and avoided the actual suspension. Because the driver's license remedy is known to be harmful, any reduction in the use of the enforcement tool should be seen as a removal of barriers to employment and parenting. If passed, we expect the ratio of payers with a suspension to decrease significantly.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			218	268	486	110	110	220
HCAF					0			0
Federal TANF					0			0
Other Fund - Special Revenue Fund			0	0	0	0	0	0
Total All Funds			218	268	486	110	110	220
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	Systems (PRISM state share @ 34%)	154	236	390	78	78	156
GF	12	Children and Family Services Admin – Transfer Out	64	32	96	32	32	64
SRF	12	Children and Family Services Admin – Transfer In	64	32	96	32	32	64
SRF	12	Children and Family Services Admin – Transfer In	(64)	(32)	(96)	(32)	(32)	(64)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Changes:

Minn. Stat. § 518A.31
Minn. Stat. § 518A.32, subds 3 and 4
Minn. Stat. § 518A.34
Minn. Stat. § 518A.41
Minn. Stat. § 518A.42, subds 1 and 3
Minn. Stat. § 518A.65

Change Item Title: Administrative Improvements for Child Care Providers

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	633	467	689	717
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	633	467	689	717
FTEs	1	4	6	6

Recommendation:

The Governor recommends investing $1.1 million in the FY 2024-2025 biennium and $1.4 million in the FY 2026-2027 biennium to centralize and streamline provider registration and renewals for the Child Care Assistance Program (CCAP) and remove duplicative background studies for Legal Non licensed (LNL) providers in CCAP.

This proposal includes the following:

- Six FTEs to establish a centralized childcare provider registration and renewal unit at the Department of Human Services (department) for CCAP.
- $368,598 to MNIT in Fiscal Years 2024-2027 for necessary changes in MEC^2 for centralized provider registration.
- $54,015 to MNIT in Fiscal Years 2024-2027 for necessary changes to MEC^2 for changes to LNL background study frequency.
- $75,000 to IA, the NETStudy 2.0 development vendor. Changes to NETStudy 2.0 are needed for the department to register LNL providers, including the initiation of LNL provider background studies.
- $275,000 in FY2024 and $55,000 ongoing to build and maintain a centralized provider registration system.

Rationale/Background:

Centralize and Streamline Provider Registration

Families who receive childcare assistance apply for assistance at the Child Care Assistance Program (CCAP) agency where they live. CCAP agencies are counties, tribes, or subcontracted agencies that administer CCAP. When a family on CCAP selects a childcare provider, that childcare provider must be registered with the same CCAP agency the family receives their assistance from to receive CCAP payments.

Currently, the CCAP childcare provider registration process is paper based. In 2023, childcare providers will be able to register for CCAP online, as part of the childcare systems transformation product. With this online tool in place, the department will be well positioned to process CCAP provider registrations. Centralizing CCAP registration through DHS will complement the streamlined online provider registration process.

Childcare providers often serve families who live in multiple counties. This results in about 40% of childcare providers registering for CCAP with multiple agencies. This is redundant and burdensome to providers and CCAP agencies. Furthermore, by registering and interacting with multiple CCAP agencies, providers experience inconsistencies in the process, which causes frustration. Examples of how the use of multiple CCAP agencies for provider registration and renewals affects providers include:

- Different CCAP agencies have varying standards for recording information from the CCAP provider registration form to the Minnesota Eligibility Child Care system (MEC^2), which can result in inaccurate, incomplete, or conflicting information in MEC^2 (Minnesota's automated IT system used to manage CCAP).
- Using multiple agencies for provider registration and renewal creates multiple points of contact at multiple agencies with responsibility for provider data, communicating with providers, and taking actions against providers. CCAP agencies vary in how they maintain a provider's registration and make decisions on when to close a provider's registration. This can result in inconsistencies in oversight during the CCAP registration and renewal process.
- For providers who are registered with multiple agencies, these renewal periods are often at different times. This causes providers to give duplicative information to the government. Depending on the CCAP agency, providers renew their registrations at either one or two years.

Providers perceive these inconsistent practices as confusing and unfair. Additionally, these redundant processes disincentivize providers from registering to receive CCAP payments, which can limit childcare options and availability for families on CCAP.

Centralizing provider registrations, renewals and closures with the Minnesota Department of Human Services (department) would lessen administrative burdens for CCAP agencies and childcare providers and reduce barriers that might discourage providers from registering for CCAP.

Remove duplicative background studies for Legal Non licensed (LNL) Providers

State and federal law allow for some childcare providers to be excluded from licensure requirements. One category of these providers is frequently referred to as "family, friend, and neighbor" providers. They are exempt from licensure if they provide childcare only for children who are relatives (not their own children) or children from one nonrelated family.[1] Family, friend, and neighbor providers fill an essential gap in the continuum of childcare in Minnesota. They frequently provide childcare for children and families with specific language, dietary or cultural needs, as well as families who need childcare on evenings and weekends. Legal non licensed (LNL) childcare providers are family, friend, and neighbor providers registered with CCAP.[2]

State and federal law require individuals working in childcare programs or providing care to undergo background studies. Minnesota law was amended in 2017 to provide that background studies for these individuals be renewed every five years.[3] This requirement applies to licensed family childcare programs, licensed childcare centers, certified license-exempt childcare centers and LNL providers. A five-year renewal cadence aligns with how background studies are completed in NETStudy 2.0, Minnesota's automated background study IT system used for childcare providers and other provider types.

When the statute was amended in 2017, a section of statute requiring LNL providers to renew their background studies every 2 years was erroneously not amended. This has created a conflict in state law[4] that results in unnecessary administrative burdens and costs that can be a barrier to family, friend, and neighbor providers becoming LNLs, and is misaligned with how NETStudy 2.0 background studies are completed. This conflict in law and practice should be remedied.

Proposal:

Centralize and Streamline Provider Registration

This proposal would move the CCAP provider registration, renewal, and registration closure processes from CCAP agencies to the department. The department would register providers, maintain their registrations, and make

[1] See: Minn. Stat. § 245A.03, subd. 2

[2] See: Minn. Stat. § 119B.011, subd. 16

[3] See: Minn. Laws, 2017, 1st Special Session, Ch. 6, Art. 16, § 21, amending Minn. Stat. § 245C.04, subd. 1

[4] See: Minn. Stat. § 119B.125, subd. 1a, requiring LNL providers to renew background studies every two years

decisions about a provider's registration in collaboration with CCAP agencies. Moving these processes to one entity would have numerous benefits.

Providers would no longer need to register with multiple agencies at multiple times in a registration period. Communication to and from providers would be streamlined since providers would have one point of contact instead of several should they need to discuss their CCAP registration with the registering agency. This proposal would also provide the department with more accurate information on its CCAP registered providers. Roles and decision-making when a provider's eligibility for CCAP is in question would be clear to the department, providers, and CCAP agencies.

Decentralized data can make some forms of fraud easier to accomplish. Centralized registration and renewal would allow the department to standardize the provider registration process and policies that effect providers and their registration. Additionally, centralizing this process would allow for better review and tracking of registration materials. This would improve consistency and oversight. Consistent policies will address stakeholder and program compliance concerns.

Effective date: April 28, 2025.

Remove duplicative background studies for Legal Non licensed (LNL) Providers

This proposal would require LNL providers to renew their background studies every five years rather than every two years. This change is consistent with background study renewals for other childcare provider types and aligns with existing NETStudy 2.0 background study functionality. It also reduces an unnecessary administrative burden for family, friend, and neighbor providers to become LNLs.

This work compliments changes CCAP has recently made regarding LNL provider rates and recent investments in family, friend, and neighbor childcare. These changes are intended to support LNL providers and the children and families they serve.

Effective date: April 28, 2025, to align with centralizing provider registration.

Impact on Children and Families:

Centralize and Streamline Provider Registration

This proposal would have a positive impact on children and families. Childcare providers have identified the CCAP provider registration process as a barrier to accepting childcare assistance payments. This proposal makes the registration process easier. As a result, more providers may register to care for children receiving CCAP. This gives families using childcare assistance more options when selecting a childcare provider.

Remove duplicative background studies for Legal Non licensed (LNL) Providers

This proposal reduces barriers to family, friend, and neighbor providers becoming LNLs, enabling more CCAP families to utilize this type of care while pursuing work or educational opportunities. In State Fiscal Year 2021, approximately 184 CCAP children received care from a LNL provider. This proposal will maintain or increase access for these families, supporting their ability to choose the type of care that best meets their needs.

During engagement sessions discussing the use of federal COVID-19 Relief funds, families and representatives from groups representing families mentioned the importance of reducing barriers for providers, which would allow children and families to access safe and reliable childcare more easily.

Equity and Inclusion:

In State Fiscal Year 2021, 68 percent of all children served by CCAP were children of color or American Indian children, specifically Black/African American, Asian/Pacific Islander, Hispanic/Latino, multiple races, and American

Indian children. Of all children served, 54% are Black/African American. Accordingly, any policy changes to CCAP are likely have the greatest positive impact on Black/African American children and families.

Centralize and Streamline Provider Registration
This provision will support children of color by reducing barriers for providers who serve them and expanding family choice of childcare providers.

Remove duplicative background studies for Legal Non licensed (LNL) Providers
This provision will support Native American and American Indian children as well as Black/African American, especially African Immigrant families. Historically, American Indian populations have utilized LNL providers at a high rate relative to other racial and ethnic groups. There has been an increase in Black or African American families who utilize LNL providers, especially among African immigrants. This provision supports family choice in childcare providers and the availability of culturally responsive childcare by reducing barriers that might prevent family, friend, and neighbor providers from becoming LNLs.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Centralizing provider registrations moves a CCAP function currently done by tribal agencies to the department. This would decrease a tribal agency's workload but would not result in a financial impact. Allowing LNL providers to renew background studies every five years will not have a direct impact on tribal agencies. However, tribal CCAP agencies and stakeholders that represent tribal families who receive CCAP from a county agency support policies that would make it easier for LNL providers to serve children and families receiving CCAP.

Impacts to Counties:

Centralizing provider registrations moves a CCAP function currently done by counties to the department. This would decrease county administrative burdens but would not affect counties financially. Allowing LNL providers to renew background studies every five years rather than every two would reduce workload for CCAP agency workers. Currently, CCAP agency workers must ensure LNL background studies are performed at their registration renewal, and in some CCAP agencies, a worker initiates the LNL background study.

IT Costs:

A portion of the funding for IT changes to support this proposal will be used to make changes in MEC^2 so providers are registered with all CCAP agencies; to disable county and tribal security to enter or approve provider registration information in MEC^2; to automate the process of sending registration renewals; to create new alerts; to create a new security role and serving agency that allows department staff to enter, update, approve, and send notices related to provider registrations; and for updates to MEC^2 PRO (CCAP's electronic billing system). The remainder of IT funding for this proposal will be used to make changes in MEC^2 so registrations will auto close if a new background study is not completed after 5 years rather than after 2 years. These are general fund costs.

Category	***FY 2024***	***FY 2025***	***FY 2026***	***FY 2027***	***FY 2028***	***FY 2029***
Payroll						
Professional/Technical Contracts						
Infrastructure						

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)	$264,132	$52,827	$52,827	$52,827		
Total	**$264,132**	**$52,827**	**$52,827**	**$52,827**		
MNIT FTEs						
Agency FTEs						

Results:

Centralize and Streamline Provider Registration

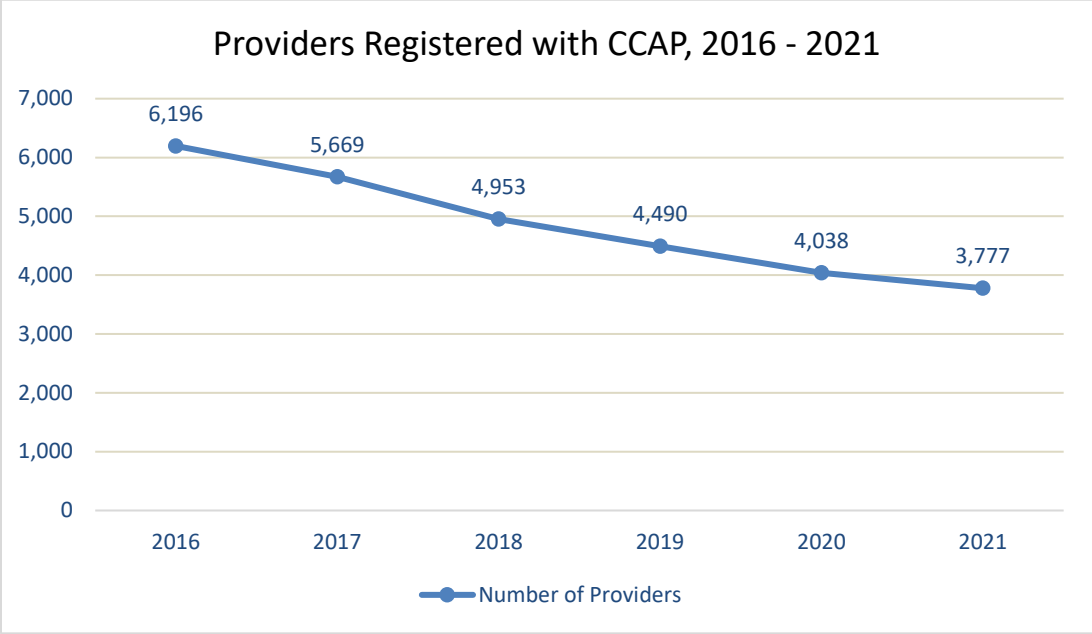
Reduced redundancies for childcare providers

Current state: Approximately 1,440 providers are registered with multiple CCAP agencies. This requires providers to submit the same registration materials to multiple CCAP agencies. Registration materials are about 13 pages of information. This results in 52,910 pages of redundant CCAP registration information to flow between childcare providers and CCAP agencies.

Future result: Duplicative registration information is eliminated for 1,440 childcare providers. Multiple CCAP agencies are no longer responsible for independently storing duplicative provider information at their agency.

Increased number of licensed childcare providers registered with the Child Care Assistance Program

- Current state: The number of childcare providers registered with the CCAP is decreasing. (See table on the next page.)
- Future result: This proposal could increase the number of licensed childcare providers registered with CCAP because barriers to registration would be reduced.



Reduced percent of providers reporting registration paperwork as a barrier

- Current state: A 2018 survey of childcare providers shows that of providers who participate in the CCAP, 19% think "too much paperwork" is a barrier to participating in CCAP. Of providers who do not take CCAP children, 48% listed "too much paperwork to get approved" as a barrier to participating in CCAP.
- Future result: In the 2024 and 2027 survey of childcare providers, less will report "too much paperwork to get approved" as a barrier to participating in CCAP.

Registrations will be processed within 10 days

- Current state: The department does not know how long, on average, it takes for a CCAP registration or renewal to be processed by a CCAP agency. In Rule 3400 as proposed, CCAP agencies are directed to process registrations within 30 days.
- Future result: The department will track the average time it takes for a provider to become registered or renewed. The department expects to complete registrations and renewals within 10 days.

Remove duplicative background studies for Legal Non licensed (LNL) Providers

Overall, the department anticipates this will reduce barriers for legal non licensed providers and increase accessibility for children and families. The CCAP Family Profile shows a downward trend of children receiving care from legal non licensed providers – from 2.9% of children in CCAP receiving care from a legal non licensed provider in fiscal year 2017 to 0.8% in fiscal year 2021.

This proposal could increase access to childcare in areas where there is an inadequate supply of childcare providers and for families employed in jobs with non-traditional work hours by reducing barriers for individuals who want to be an LNL provider.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 27-28
General Fund			633	467	1,100	689	717	1,406
HCAF					-			-
Federal TANF					-			-
Other Fund					-			-
Total All Funds			633	467	1,100	689	717	1,406
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 27-28**
GF	12	Children and Family Services Admin (6 FTEs)	142	563	704	890	931	1,820
GF	REV1	FFP @ 32%	(45)	(180)	(225)	(285)	(298)	(582)
GF	11	MEC2 Changes - provider registration, LNL background study frequency change & NETStudy 2.0 (state share @55%)	186	29	216	29	29	58
GF	12	Net 2.0 Study	75		75			
GF	12	Provider Registration	275	55	330	55	55	110
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 27-28**
			1	4	4	6	6	6

Statutory Change(s):

119B.011, 119B.125, 119B.13, 119B.16, 119B.161, 245C.04, 245C.05, 245C.11, 245C.17, 245C.23, 256.046, 256.983

Change Item Title: Integrated Services for Children and Families

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	15,326	10,810	8,635	6,263
Revenues	0	0	0	0
Special Revenue Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	15,326	10,810	8,635	6,263
FTEs	**27**	**27**	**27**	**25**

Recommendation:

The Governor recommends a general fund investment of $26.1 million in FY 2024-25 and $14.9 million in FY 2026-27 to support key systems work for child support, child protection/child welfare, and economic support information systems.

Rationale/Background:

Deficiencies in Department of Human Services' (department) technology systems prevent us from supporting Minnesota's children and families in a more person-centered, holistic way. Our aging technology systems create inefficiencies for workers and audit findings for noncompliance with state and federal statutes and regulations. The department identified the steps contained in this proposal as critical both to the experience of the people we serve and to program integrity. This proposal was identified in partnership with administrations across the department and is informed by regular feedback from frontline workers about the inefficiencies of our technology, as well as deficiencies identified in state and federal audits. This proposal relies on three strategies:

1) Stabilize existing systems so that they serve us better now, while also positioning us for future modernization of those systems.
2) Implement innovative solutions to transform the experience of the families we serve and streamline the worker experience, with an eye for alignment with compliance-related findings and agency-wide technology strategy.
3) Prepare for future transformation based on stakeholder feedback and strategic alignment to the agency-wide vision for service delivery transformation.

Proposal:

This proposal seeks critical funds for existing technology, builds on current innovative work, and plans for future technology innovations to improve the experience and outcomes of the people we serve.

Strategy 1: Stabilize Legacy Systems (MAXIS/MEC^2/SSIS)

Together, MAXIS and MEC^2 (Minnesota Electronic Child Care) are responsible for delivering more than $1.9 billion in benefits to hundreds of thousands of Minnesotans. MAXIS is used by state and county workers to determine eligibility for public assistance and health care, such as Minnesota Family Investment Program (MFIP), refugee cash assistance and food support, as well as for determining and issuing benefits for cash and food support

programs. MEC^2 is used to deliver Child Care Assistance Program (CCAP). SSIS was implemented in 1999 to meet 1993 federal requirements for gathering data regarding child protection investigations and the out-of-home placement of children. Several additional program areas also use the system, such as adult protection. The system has approximately 11,000 users and served 596,000 distinct clients in 2021. PRISM is a federally mandated system that supports child support enforcement with receiving and disbursing child support payments, identifying non-custodial parents and other tasks.

- Tackling the backlog for eligibility systems

Increased costs and stagnant or decreased investments over time have eroded staffing levels to support MAXIS and MEC^2 to less than half the IT staffing capacity (40 FTEs) that existed in 2010. Reduced staffing capacity for these critical systems has resulted in a less-than-functional eligibility system in which workers are doing manual workarounds while identified updates, fixes and efficiencies sit in a growing queue for years at a time. This also results in slower, inaccurate services for the Minnesotans receiving assistance. The State is under a program improvement update from the USDA to bring down the error rate in the Supplemental Nutrition Assistance Program (SNAP) and millions of dollars are lost to the department via interim assistance recovery.

This proposal invests $2.2 million annually from FY2024 to FY2026 for program and technical staffing to eliminate the MAXIS/MEC2 backlog, resulting in an improved experience for Minnesotans receiving assistance and improved program integrity. Bringing the systems up to date will also prepare them for a smooth transition to newer technology. Federal matching funds will pay 45% of that cost. The state share is $1.198 million per year from FY2024 to FY2026. The project is estimated to be completed by FY2026.

- MAXIS, PRISM, and MEC² System Sustainability

MAXIS, PRISM, and MEC² are mission-critical systems for DHS, counties and Tribal Nations to serve the citizens of Minnesota. As modernization efforts have slowed, dependency on these important legacy systems has continued, despite decreasing available funding. Staffing has been reduced by 60% over the last 5 years, yet the number of changes required continues to grow. Additional staffing is needed to continue to keep the systems viable for the next 5-10 years and replace staff as they retire.

Increasing staffing levels will ensure the following critical work is performed:

- Software upgrades, monitoring, applying security patches, batch support, documentation and security diagrams.
- Projects and system change requests will be completed in a timely manner and reduce resource contention for critical efforts.
- MAXIS reporting position for WEBI and Tableau tools

This includes 8 permanent FTEs for the department who will provide subject matter expertise and complete user acceptance testing to ensure long term sustainability for MAXIS, MEC2 and PRISM. The state share of the cost for the system is $2.1 million from FY2024 through FY2026.

- SSIS Sustainability

Funding is needed to sustain SSIS until it can be modernized, and to address the SSIS Performance and Sustainability Workgroup Recommendations that resulted from the work of the Minnesota Association of County Social Service Administrations (MACSSA). This funding will ensure significant improvements in the performance of SSIS for county and tribal workers.

The total cost of this proposal is $1 million in FY2024. The state share would be $520,000 (52%).

Strategy 2: Implement Innovative, Modern Solutions

This strategy builds on existing innovative work using three different processes:

- Child support modernization

This proposal invests in modernizing the child support system, which is used by approximately 1,500 county staff and serves 324,000 parents and 226,000 children. The approach to systems modernization includes moving from an unsustainable legacy platform and programming language to a newer language (such as Java or .net) and enhancing user experience. The first process is refactoring, which converts older code into a modern programming language, which requires minimal staffing. Refactoring would result in updated screens for county child support workers, making PRISM easier to navigate.

The second process is replatforming which moves the child support system off the mainframe into a modern web-based environment. This approach was found to be the least costly option identified by the federal Office of Child Support Enforcement (OCSE) and has been successfully used by other states. It has the added advantage that the department would not need to complete a feasibility study or apply for system recertification, which are both lengthy processes.

The third process involves transformation of the participant portal following replatforming and refactoring, to increase the capacity to update information for the participant, which was widely identified as a desired improvement by focus groups, surveys, and staff. This will be achieved through an off-the-shelf product, which fits into the State's "Rent, buy, build" model. Transformation could also result in more flexible payment options, and an easier process for requesting modifications to orders.

This request takes an incremental approach. The three processes are expected to be completed by FY 2026 after which the department would seek ongoing funding to enhance case management functions and automate business functions which would lead to increased efficiency.

The total MNIT cost for this provision is $23.3 million in FY2024-25 and $18 million in FY2026-27. Federal matching funds will cover 66% of this cost. The state share is $7.939 million in FY2024-FY2025 and $6.12 million in FY2026-2027. Additionally, DHS will hire one permanent FTE to support this work, at a total cost of $286,000 in FY 2024-25 and $306,000 in FY 2026-27. State share for this FTE will be $97,000 in FY2024-2025 and $104,000 in FY 2026-2027.

- SSIS Review

The amount of data entry, functionality and data storage requirements added to the SSIS system over time have overwhelmed the capacity of the system. In addition SSIS has not adapted to a mobile or remote workforce. The result is that system performance has become inconsistent and sub-standard, creating a significant barrier to effectively serving the needs of families. Common problems experienced by social workers from across the state include repeated outages, system crashes, and missing or unsaved data. Poor SSIS functionality has become an urgent problem. At this time, we are faced with two challenges:

1. Address existing urgent problems in the current SSIS system

    a. Burdensome or unnecessary data entry requirements necessary as implemented by DHS Policy changes over the years
    b. Technical problems that may require changes in the application, the supporting software and hardware, as well as infrastructure at the state and county levels.

2. Determine the best platform for a modernized system that best serves social workers and families.

This proposal would pay for an independent consultant to do a thorough examination of the existing system. The consultant would use their experience in Enterprise Architecture, Agile methodologies, and user-centered design to help improve how the department and local agencies are doing our work. The department would work with a consultant who can help determine a platform for future development and determine if MNIT has the existing capacity to do that work or if a customizable off-the-shelf (COTS) product would be a better option to replace SSIS.

The cost of this provision is $1 million in FY2024 and $1 million in FY2025.

- Child Welfare Data Integration and Exchange

In 2018, the department declared to the federal Administration of Children and Families that it would comply with new regulations for the Social Services Information System (SSIS), the technology system that provides child welfare case management. These federal requirements are known as Comprehensive Child Welfare Information System (CCWIS) requirements. The Department has made some progress toward implementing the new standards. The next steps include investment in data sharing and integration along with user support and training.

Specifically, we will implement cross-agency data sharing to promote comprehensive and coordinated child welfare services across agencies/departments to improve outcomes for children, adults and families in Minnesota. This proposal will create bi-directional data exchanges with the Minnesota Department of Education and Minnesota Judicial Branch, as well as an improved exchange with the Medicaid Management Information System (MMIS). This will result in the reduction of duplicate or unnecessary data entry (including entry of the same or similar data in multiple data systems, e.g., SSIS, MNCIS, or MDE applications). We will also plan and operationalize a process for data collaboration and exchange with child welfare contributing agencies (CWCAs). CWCAs are public or private agencies that, through contract, provide child abuse and neglect investigations, out-of-home placements or child welfare case management.

These improvements, along with increased support for users and quality assurance, will not only improve the system today, but will also pave the way for future modernization of SSIS.

The cost for this proposal is $573,000 annually in FY2024 through FY2026. Starting in FY 2027, the cost is $115,000 per year to maintain the changes. Federal matching funds will pay 48% of the cost. The state share is $596,000 in FY2024-2025 and $358,000 in FY2026-2027. In addition, this proposal includes 9 permanent FTEs for the department to implement needed changes and provide user support. The total cost of these positions is $1.1 million in FY2024 and $1.2 million in FY2025 and on. The state share of these positions will be $1.4 million in FY2024-2025 and $1.5 million in FY2026-2027.

- Improved Communication

The department will develop an enterprise approach to communicating with program participants through electronic channels, such as secure e-mail, texting, chat, and client portals. In addition, this proposal will fund improvements to notices, including implementing plain language practices to help people understand what actions have been taken with their case and what steps they may need to take. This proposal will also improve our technology so that notices are easier to update as appropriate. This proposal leverages previous and current work related to texting and notices to ensure that we continue to deliver improvements in communication in a way that is aligned across department programs.

The total cost includes $7 million dollars for notice improvement and $4.5 million to add texting options in FY2024 in systems costs. The cost is $875,000 in FY2025 and ongoing. The general fund will pay a share of these costs depending on system, outlined in the fiscal detail below. The state share will be $6.4 million in FY2024-2025 and $815 thousand in FY2026-2027. The cost includes 2 temporary FTEs for the department to implement needed changes and provide user support beginning in FY2024 and ending in FY2027. Additionally, FTEs responsible for reducing the MAXIS/MEC2 backlog will also support this transition.

Strategy 3: Identify Next Steps

This strategy provides staff to analyze next steps toward sustainable technology that improves the experience of children and families in Minnesota while enhancing program integrity and reducing the burden on workers. Over the next two years, the department will also identify concrete next steps to build on the items in this proposal to continue making progress towards modern, sustainable technology. This strategy includes funding for community engagement and staff training.

The cost for this provision is $1.2 million in FY2024 and $1.4 million per year thereafter. This investment supports 6 permanent FTE for Business Integration Division (five of which are existing employees) to coordinate planning and implementation of future Children and Family Administration systems work, and to act as business project managers for components of the proposal and 2 permanent FTE for Change Management and Evaluation staff (DHS Operations) to provide strategies to ensure that staff are prepared for service delivery transformation and to measure progress toward expected results.

Impact on Children and Families:

This proposal builds on stakeholder feedback on how best to improve the experience for children and families who participate in human services programs and addresses key program integrity issues that will result in both an improved experience for families and workers and improved accuracy. For example:

- Tackling the MAXIS/MEC2 backlog will help address the SNAP error rate, which has been cited by the Office of the Legislative Auditor and the United States Department of Agriculture. Reducing the error rate is better for families, who by federal law must repay SNAP overpayments.
- Expanding methods of communication will meet families where they are. In a survey of participants from a recent Child Support texting pilot program, 81 percent of respondents stated that they would like to continue to receive information by text message, and 73 percent indicated that they would like to receive more information via text message than they did during the pilot.
- Modernization of the Child Support system will enable functionality that families have been asking for, such as additional payment and self-service options.
- Data from a recent report from the Wilder Research report indicates that people prefer to communicate in mobile-friendly ways.
- Families who are involved with child welfare programs will benefit from the bidirectional data exchanges with the Minnesota Department of Education and State Juvenile Court system, resulting in expedited services, supports, and secure information sharing between state agencies and counties/tribes; eliminating redundant activities and data entry and increasing caseworker time with individuals and families being served.

Equity and Inclusion:

This proposal will help the department reduce or eliminate inequities in several ways.

Child Support: Recently, the Child Support Division worked with counties to engage in a few pilot projects that take a more collaborative approach to enforcement, including using more digital ways to communicate with

participants and proactively contacting parents who are in arrears before suspending their driver's license. Moving the system off the mainframe and enhancing the user portal will allow for some of these changes to take place, many of which would be difficult to implement using our current system. The collaborative approaches to enforcement will target inequities in the child support program.

An example of this would be disproportionality in child support enforcement caseloads. For example, we have found that among those who enter the process for their driver's license to be suspended, 18% of white individuals end up having their license suspended, but that rate is much higher for African Americans (32%), American Indians (42%) and Hispanics (22%). The program has been pivoting to an approach that considers the whole needs of the family and tries to remedy this inequity and is currently working with several counties on a pilot program to develop remedies to driver's license suspension in concert with the family. However, our current system does not lend itself to a customized case management approach, which makes it difficult to implement these types of solutions on a wider scale or without significant manual work in the system.

Child Welfare: Improved data sharing and data quality will allow us to better understand and monitor where inequities and disproportionate recommendations exist.

Improved Communication**:** Our inability to communicate electronically with recipients disproportionately impacts those who are in transition. Expanding texting and implementing standards across the agency would allow us to more efficiently reach recipients via text message. For those who do still receive the paper notices, the notice improvements will lead to easier to understand and more actionable notices for recipients.

Planning and Engagement**:** This intentional planning step allows us to do the necessary engagement and analysis to determine what the next best steps are for improving our technology and systems to meet the needs of children and families in Minnesota.

Impacts to Counties:

Strategy 1: Stabilize Legacy Systems
Our eligibility systems are already difficult for county workers to learn to use, and the number of manual workarounds currently in place adds to that challenge. Eliminating those workarounds will reduce that burden. The SSIS sustainability component specifically addresses county concerns about technical problems and performance issues.

Strategy 2: Implement Innovative, Modern Solutions
Child Support Modernization**:** Counties have been asking for modernization for more than 15 years. CSD engaged counties in a process improvement study completed by Deloitte in 2009. That study engaged county stakeholders. CSD has several established ways to interact with counties including a County Advisory Board.

Child Welfare Data Integration and Exchange: Counties continue to ask for better data sharing and integration. This proposal allows for increased data integration in order to serve children and families better on a case-by-case basis and more broadly as the integrated data allows the state to identify trends and monitor outcomes.

Improved Communication**:** Improved notices will lead to clearer information for recipients and fewer calls to county workers with questions about notices. Developing a strategy and standards for text messaging will benefit counties who would like to implement a similar solution.

Strategy 3: Identify Next Steps
Counties would be an important part of the planning process. They have indicated a desire to co-create solutions and proposals with the department, and this proposal provides additional state resources to ensure that this engagement can occur.

Impacts to Tribes:

These proposals benefit the tribes that use each system. In each case, some tribes may use a particular system, while others may not.

Strategy 1: Stabilize Legacy Systems (MAXIS/MEC^2)
Our eligibility systems are already difficult for workers from tribal nations to learn to use, and the number of manual workarounds currently in place adds to that challenge. Eliminating those workarounds will reduce that burden.

Strategy 2: Implement Innovative, Modern Solutions

Child Support modernization: Workers will benefit from the modernized functionality for child support case management.

Child Welfare Data Integration and Exchange: Tribes will see benefits similar to the county benefits described above: more holistic, person-centered data to serve families better and identify broader trends. In addition, the department will ensure that any potential changes to the use of data from the tribes will be discussed with tribes well in advance.

Improved Communication**:** Any member of a tribal nation who receives benefits through a department program will benefit from improved communication methods and notices that are easier to understand and act upon, which will lead to less confusion for workers.

Strategy 3: Identify Next Steps
In identifying next steps to serve children and families better with improved technology, it is important that we engage and consult with tribal nations from the beginning. The department will work with tribal nations and the Office of Indian Policy to identify the best methods to authentically engage with tribes in the ways that work best for them.

Results:

Strategy 1: Stabilize Legacy Systems (MAXIS/MEC^2)
Quantity: The department and MNIT are currently in the process of reorganizing the way we track systems work. This will allow us to measure the list of current items that need attention (referred to as the "backlog") to understand the current state of the backlog. The resources funded by this proposal should lead to a significant reduction of the backlog over the next two years.

Quality: The new governance processes referenced above will lead to a prioritized list of the work. We should see that the top priority work is completed in a timely manner (relative to effective dates and MNIT's initial level of effort estimates).

Results: This strategy should contribute to decreased negative audit findings and improved customer service (measures to be established). An example of a current finding that should be improved as a result of this effort is the SNAP error rate.

Strategy 2: Implement Innovative, Modern Solutions

Quantity:

- PRISM will be refactored and replatformed with an acceptable level of stability.
- The department will achieve initial CCWIS compliance and will therefore retain our higher federal reimbursement rate. Without CCWIS compliance, SSIS will lose $1.2 million per year in federal reimbursement.
- The department will have standards for texting recipients.
- Notices from the MAXIS/MEC2 programs will federal standards as well as department accessibility standards.

Quality:

- Child support program's quadrennial survey will show improved customer service as a result of the changes to PRISM.
- Child welfare data will improve under the data quality plan submitted to the Administration for Children and Families.
- The department will expand text messaging capability beyond its current use. Standards and technology will be applied consistently across programs (specific measures to be established with standards).
- Notices from the MAXIS/MEC2 programs will be easier to understand, as established during SNAP technical assistance (additional measures to be determined).

Results:

- The child support program will be able to implement the flexible enforcement measures to reduce disproportionality in the program.
- Agencies that collaborate to support child welfare will have access to the data they need to serve families better. This will result in more person-centered services and less duplicate data entry.
- As a result of expanded text messaging capability, families will report that they have better access to the information they need about their services (measures to be established).
- Improved notices and texting opportunities will lead to fewer questions asked of counties about what action is needed on their cases. Some counties will have data about the number and type of phone calls received. Qualitative research will also be needed.

Strategy 3: Identify Next Steps

Quantity: The department will have an actionable plan for the next phase of systems improvements. Stakeholders will have provided input to the plan at key stages throughout plan development.

Quality: The department action items will align with agency strategies around technology enhancements

Results: The department will have a clear and actionable plan for the next phase of systems improvements that build upon demonstrable results from the work in this proposal.

IT Related Proposals:

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll						
Professional/Technical Contracts						
Infrastructure						
Hardware						

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)						
Total						
MNIT FTEs	17	17	17	17		
Agency FTEs	27	27	27	27		

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			15,326	10,810	26,136	8,635	6,263	14,898
HCAF					-			-
Federal TANF					-			-
Other Fund					-			-
Total All Funds			15,326	10,810	26,136	8,635	6,263	14,898
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	MAXIS & MEC2 Backlog @ 55% state share	1,198	1,198	2,396	1,198	-	1,198
GF	12	MAXIS & MEC2 Improvements - Children and Families DHS Staff (6 FTE)	813	942	1,755	942	942	1,884
GF	15	MAXIS & MEC2 Backlog - BHDH Staff (2 FTE)	265	306	571	306	306	612
GF	11	SSIS Sustainability @ 52% state share	520					
GF	11	PRISM Sustainability @ 34% state share	306	306	612	306		
GF	11	MAXIS and MEC2 Sustainability @ 55% state share	413	413	825	413		413
GF	11	Child Support modernization (PRISM) @ 34% state share	3,383	4,556	7,939	3,060	3,060	6,120
GF	12	Child Support modernization 1 DHS FTE	133	153	286	153	153	306
GF	12	SSIS Review (PT Contract)	1,000	1,000	2,000			-

GF	11	SSIS Child Family Data Integration Exchange SSIS cost @ 52% state share	298	298	596	298	60	358
GF	12	SSIS Child Family Data Integration Exchange, Children and Families Staff (9 FTEs)	1,063	1,228	2,291	1,228	1,228	2,456
GF	11	Improved Communication (Notices) MAXIS @ 55% state share	3,850	-	3,850			-
GF	11	Improved Communication (Texting), MAXIS, MEC2 @ 55% state share	281	56	338	56	56	113
GF	11	Improved Communication (Texting), METS @ 38% state share	1,068	213	1,281	214	214	427
GF	11	Improved Communication (Texting), PRISM @ 34% state share	187	37	224	37	37	75
GF	11	Improved Communication (Texting), non-state systems	601	100	702	100	100	201
GF	12	Improved communication (Texting and notices) Children and Family Services (2 FTE)	274	318	592	318		318
GF	12	Change management, Children and Family Services (6 FTE)	905	1,065	1,970	1,065	1,065	2,130
GF	11	Change management, Children and Family Services (2 FTE)	283	330	613	330	330	660
GF	REV	FFP @ 32%	(1,515)	(1,709)	(3,225)	(1,389)	(1,288)	(2,677)
		Requested FTE's						
Fund	**BAC T#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF			27	27	27	27	25	25

Change Item Title: Community Resource Centers

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	1,504	13,529	17,000	17,000
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenue)	1,504	13,529	17,000	17,000
FTEs	**10.5**	**10.5**	**10.5**	**10.5**

Recommendation:

The Governor recommends $15.033 million in FY 2024-2025 and $34 million in FY 2026-2027 from the general fund to implement a network of sustainable Community Resource Centers to promote family and community well-being. Families who have what they need are less likely to experience the child protection system and/or other deep-end service systems. Community Resource Centers have three primary goals aimed at improving child and family well-being:

1. **Make it easier for families to get what they need.** Develop physical and virtual access points for families that support relationship-based, culturally appropriate program/service navigation and/or case management.
2. **Increase access to services.** Partner with the state in using tools for program/service navigation: Help Me Connect, MNBenefits and Children Defense Fund – MN's Bridge to Benefits; case/data management tools and work to increase service infrastructure where necessary.
3. **Grow community engagement and feedback loops.** Identify and execute feedback loops with community organizations to better support families, remove policy barriers; and build community capacity to better serve families.

Statewide family and community engagement over the past 3 years has indicated that families want more accessibility to supportive programming and concrete supports. Preschool Development Grant (PDG) Community Resource Hubs were created using time-limited federal grant funding with that accessibility in mind. This proposal works to build upon the successes of the PDG Community Resource Hubs; Full Service Community Schools; Family Resource Centers; Community Action Agencies; and more to: serve more families and communities across the state – especially families and communities furthest from opportunity due to race/ethnicity, income, and geography; and drive for improved family and community well-being outcome.

Rationale/Background:

Poverty and economic insecurity continue to create adverse environments and experiences for children and families across Minnesota – including, but not limited to, neglect and maltreatment. Economic, social and environmental factors – including structural racism, historical trauma, and adversity ensure that not everyone has access to the conditions and opportunities that support and promote child and family well-being.

Extensive community engagement across the state indicates that families feel that they do not have access to programs and services that promote economic stability and family well-being. This is especially true for families who live in communities with fewer protective factors.

Protective factors are conditions or attributes in individuals, families, and communities that promote the health and well-being of children and families and support families during times of stress. When there are ample protective factors at the family and community level, children and families are more likely to experience healthy functioning and positive short and long-term health and well-being outcomes.

At the family level, protective factors may include (all with regard to the race, ethnicity, and culture of the family):[1]

- Concrete supports for parents
- Nurturing and attachment
- Knowledge of parenting
- Parental resilience
- Social connections

At the community level, protective factors may include (all with regard to the race, ethnicity, and culture of the community):[2]

- Availability of economic and financial help
- Availability and access to medical care and mental health
- Availability and access to safe, stable housing
- Availability and access to nurturing and safe childcare and pre-kindergarten
- Availability and access to after school programs and activities
- Availability and access to family friendly work opportunities
- Partnerships between community and business, health care, government and other sectors
- Availability and access to social connectedness and community involvement
- Communities where violence is not tolerated or accepted

Research from Chapin Hall at the University of Chicago suggests that family economic stability and concrete supports are a best first step in promoting child and family well-being and family protective factors and preventing involvement in the child protection system.[3] Based on population estimates and data collected through SSIS, during 2021, American Indian children are about 4-5x more likely than white children to be reported to the child protection system. Children identified as two or more races are about 4x as likely and Black children are about 2x as likely to be reported to child protection. Creating a network of Community Resource Centers are a documented way to support family and community protective factors over time and reduce child welfare system involvement.[4]

Design and access points for programs and services are less accessible to some families than others. Data collected from current PDG Community Resource Hubs indicates that families are requesting access to economic stability programs at a higher rate than any other programs. Services most asked for by families include financial assistance, health care, food, housing, childcare access, and employment services.

Intended results for the proposal include families having culturally responsive access to critical programs and services that promote family economic stability and well-being and prevent child welfare system involvement.

Proposal:

This proposal establishes and funds a network of Community Resource Centers that will offer culturally responsive, relationship based service navigation and concrete supports as well as other community driven

[1] Protective Factors to Promote Well Being and Prevent Child Abuse and Neglect
[2] CDC Risk and Protective Factors
[3] Addressing Economic Hardship Key to Preventing Child Welfare System Involvement
[4] Do Family Support Centers Reduce Maltreatment Investigations? Evidence from Allegheny County

programs and services that create protective factors and support family well-being. This proposal builds on the work of several existing efforts, including but not limited to: PDG Community Resource Hubs; Full Service Community Schools; Family Resource Centers; Community Action Agencies; Parent Support and Outreach Program; MN Benefits; and Help Me Connect.

Community Resource Center grants will be available to a broad array of entities including but not limited to: community-based agencies, local governments, Tribal Nations, counties, school districts, community action agencies, and collaboratives including one or more mentioned entity. Entities are encouraged to engage in community planning that includes the following partners to ensure viable referral networks, partnership, co-creation, and community needs are met:

- Parents and families with lived experience (families that have or are using state, county, Tribal social services, public health services, education services or previous involvement in the child welfare system)
- Community based service providers
- Community Action Agencies
- School districts
- County social services
- Local public health
- Local government
- Local law enforcement
- Existing family services or mental health collaboratives
- Local food shelves/banks
- Regional hospitals or clinics

Interested Tribal Nation grantees will self-determine planning partners and engage in community planning as benefits them.

Grantees will provide for the following: relationship-based, culturally responsive service navigation including referrals and follow up; eligibility inquiries; application support; cultural practices related to well-being and light case management for families when appropriate; concrete supports; and robust family and community engagement and feedback loops to determine additional service array. Grantees will form or use an existing parent advisory counsel to guide the work of the grantees. Entities may apply for planning or implementation awards. Awarded grantees will provide a minimum 10% award match.

Infrastructure to support network includes providing training on navigation tools and professional development; communities of practice and networking; research and evaluation; IT support; grant management and planning and interagency support.

DHS will also form an advisory counsel to do the following: advise the commissioner on the development of the request for proposals for community resource center grants; consider how to build on the capacity of communities to promote child and family well-being and address social determinants of healthy child development; review responses to requests for proposals and advise the commissioner on the selection of grantees and grant awards, advise the commissioner in the development of outcomes, ongoing oversight and necessary support in the implementation of the program. The advisory counsel will include up to 14 individuals including parents, DHS staff, Tribes, counties, community based organizations and with demographic and geographic diversity.

Use of funds

This proposal assumes serving approximately 60,000 families and their communities per year.

The proposal would be fully implemented in FY2025 with planning occurring in FY2024. The funds will support 10.5 FTE, including:

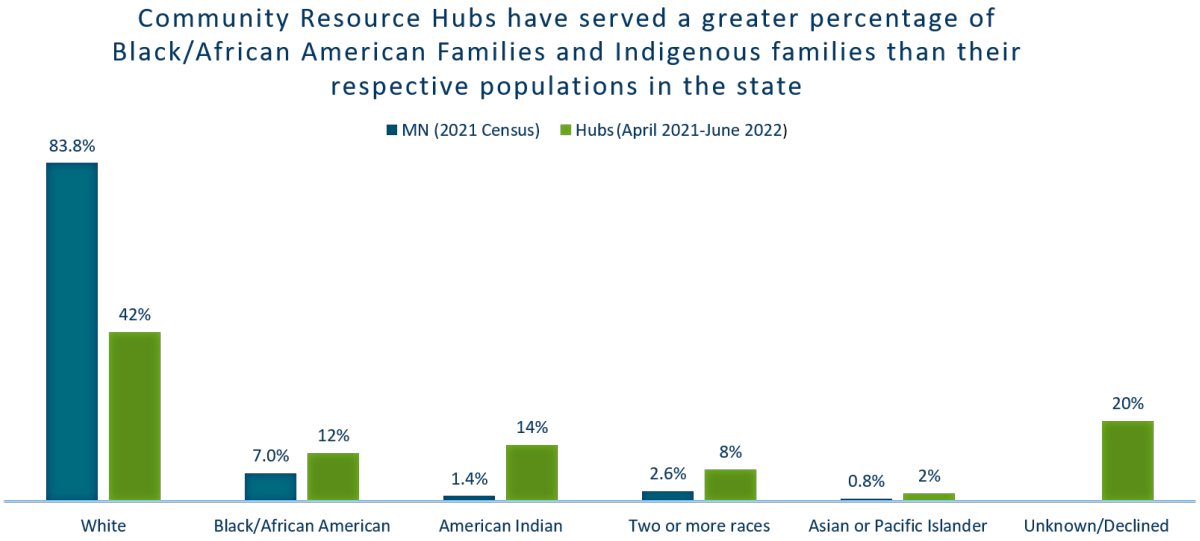
- FTE Community Resource Center Lead 17L
- FTE Community Resource Center Consultant 14L
- FTE Community Resource Center Concrete Support Specialist 14L
- FTE Community Resource Center Operations Specialist 14L
- FTE Community Resource Center Indigenous Liaison 17L
- FTE Mental Health Consultation Coordinator 17L
- FTE Information Technology Spec 4
- FTE Information Technology Spec 5
- FTE DHS Financial Operations 14L
- .5 FTE Department of Education Liaison/TA Specialist 14L
- .5 FTE Department of Health Liaison/HMC and TA Specialist 14L
- .5 FTE Department of Management and Budget Children's Cabinet Liaison 14L

Impact on Children and Families:

Families accessing services and concrete supports promotes family protective factors. This proposal provides solutions for the development of community and family protective factors through creating more access for more families to programs and services at the community level – making it easier for families to get what they need to achieve economic stability and well-being. Family economic stability and well-being is associated with lower rates of child welfare involvement and neglect reporting. Other outcomes may involve school readiness and school success; child development and growth; community violence; community economic stability; and more.

Equity and Inclusion:

Black, Indigenous, and Families of Color have historically been overrepresented within the child welfare system starting with the reporting process. Engagement and feedback loops with families and communities experiencing inequities due to race/ethnicity, income, and geography indicate families do not feel safe in stepping into county buildings to ask for support. The PDG Needs Assessment and Strategic plan as well as the Thriving Families Safer Children priorities are focused on increasing access to services in a culturally responsive and inclusive way through Community Resource Centers. Initial pilot data from the PDG Community Resource Hubs indicate that Hubs are serving a greater percentage of African American families and Indigenous families than their respective populations in the state.



As with the current PDG Community Resource Hubs, the proposed network will focus on promoting well-being for communities and families furthest from opportunity due to race/ethnicity; income; and geography through increased access to economic supports and critical services and seeks to reduce the disproportionality of Black, Indigenous, and Families of Color involved in the child welfare system. Additionally, ensuring grants go first to communities that are furthest from opportunity due to race/ethnicity, income, and geography moves toward less disproportionality within the child welfare system.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

While this proposal has an impact on Minnesota's tribes, they have not been formally engaged or consulted regarding this proposal due to limited time. As stated, all eleven tribal nations were a part of initial PDG stakeholder engagement and seven tribes are either directly funded or site partners in the current Community Resource Hubs Pilot.

- Northland Foundation, in partnership with Fond du Lac Band of Lake Superior Chippewa and community stakeholders in Grand Portage Band of Lake Superior Chippewa, Leech Lake Band of Ojibwe, and Mille Lacs Band of Ojibwe.
- Northwest Foundation, in partnership with White Earth Band of Chippewa, and Red Lake Nation,
- Red Lake Nation, Minneapolis Urban office, Ombimindwaa Gidinawemaaganinaadog (Uplifting Our Relatives)
- Sawtooth Mountain Clinic, in partnership with Grand Portage Band of Lake Superior Chippewa.

Tribal nations and urban tribal entities would be eligible for Community Resource Center grants. Tribes participating in the American Indian Child Welfare Initiative (Initiative) could see similar reductions in family involvement in child welfare systems. Serving the Indigenous/American Indian population through Community Resource Centers, including trauma informed, relationship based, culturally responsive service navigation and provision could also result in lower rates of disproportionality within the child welfare continuum.

Impacts to Counties:

The department has worked in collaboration with many partners including MACSSA to develop this proposal. County partners believe Community Resource Centers and similar models will broadly reduce entry into the child welfare system and eventual out of home placement.

Implementing Community Resource Centers creates more options for referral and supports for families who counties don't believe belong in the child welfare system yet need critical supports to promote well-being. In particular, county administrators and advocates note similar models as critical resources in meeting the needs of families at risk of entry into the child welfare system due to educational neglect and other related neglect allegations.

IT Costs:
Costs include purchase and implementation of case management platform and annual product licensing for each Community Resource Center and any site partners each grantee may have.

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll	317,199	317,199	317,199	317,199	317,199	317,199
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software	600,000 Purchase case mgmnt. platform	299,250 Product licensing	299,250 Product licensing	299,250 Product licensing	299,250 Product licensing	299,250 Product licensing
Training						
Enterprise Services						
Staff costs (MNIT or agency)						
Total	**917,199**	**616,449**	**616,449**	**616,449**	**616,449**	**616,449**
MNIT FTEs	2	2	2	2	2	2
Agency FTEs						

Results:

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Number of families served		9,607 families	April 2021-September 2022
Quality	Number of Referrals/Successful referrals*		6,357/ 4,189	April 2021-March 2022
Results	Eventual community and family protective factor outcomes			

*Multiple barriers for referral success including lack of available service in the geographic area i.e. transportation, mental health care, child care, and more.

Evidence base and evaluation
There is nationally collected evidence that promotion of economic stability and well-being through protective factors at the family and community level provide for lower rates of families entering the child welfare system as well as other broad educational and health outcomes as noted elsewhere in this proposal. See the PDG Community Resource Hub Interim Report for further information on Community Resource Hubs. As well, similar models such as Family Resource Centers have been found to increase protective factors and prevent child maltreatment. Similar models have also demonstrated cost savings.

While results of the Community Resource Hub model have been positive any expansion would require the development of outcomes and corresponding measures. Using the protective factor survey PFS/PFS2 (developed

and validated by FRIENDS National Center in collaboration with the University of Kansas Institute for Educational Research and Public Service and can be found on the California Clearninghouse on Evidence Based Practices). The PFS/PFS2 utilize a pre and post test to measure family protective factors. This coupled with other community based tools would also contribute to continued quality improvement efforts.

Note: The U.S. Department of the Treasury requires activities funded with ARPA State and Local Recovery Funds to report on whether the services delivered are evidence-based. Recipients are exempt from reporting on evidence-based interventions in cases where they conduct an evaluation, in particular, one that can assess the causal impact of a program.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			1,504	13,529	15,033	17,000	17,000	34,000
HCAF					-			-
Federal TANF					-			-
Other Fund					-			-
Total All Funds			1,504	13,529	15,033	17,000	17,000	34,000
Fund	**BACT#**	**Description**	**FY24**	**FY25**	**FY24-25**	**FY26**	**FY27**	**FY26-27**
GF	45	Grantstocommunityresourcecenters	-	11,005	11,005	14,424	14,424	28,848
GF	12	Communityofpracticeengagement	-	200	200	200	200	400
GF	12	Trainingandconferencesupport	-	250	250	250	250	500
GF	12	Mentalhealthconsultationforgrantees	-	600	600	600	600	1,200
GF	12	Researchandevaluation	75	150	225	150	150	300
GF	12	Advisorycouncil	65	65	130	65	65	130
GF	12	Casemanagementplatform	600	299	899	299	299	598
GF	12	ChildrenandFamilyAdmin(7.5)	1,021	1,184	2,204	1,260	1,260	2,520
GF	11	MNITAdmin(2FTE)	317	317	634	317	317	634
GF	11	FODFTE(1FTE)	133	153	286	153	153	306
GF	REV1	AdminFFP@32%	(707)	(694)	(1,401)	(718)	(718)	(1,436)
		RequestedFTE's						
Fund	**BACT#**	**Description**	**FY24**	**FY25**	**FY24-25**	**FY26**	**FY27**	**FY26-27**
GF	12	ChildrenandFamilyAdmin(7.5)	7.50	7.50	7.50	7.50	7.50	7.50
GF	11	MNITAdmin(2FTE)	2	2	2	2	2	2
GF	11	FODFTE(1FTE)	1	1	1	1	1	1

Statutory Change(s):

This proposal requires a new statute to establish Community Resource Centers.

Change Item Title: Preserving American Indian Families

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	5,988	6,242	6,477	5,949
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	5,988	6,242	6,477	5,949
FTEs	**14**	**14**	**14**	**11**

Recommendation:

The Governor recommends investing $12.2 million in FY 2024-25 and $12.4 million in FY 2026-27 for the expansion of the American Indian Well-Being Unit (AIW) at the Department of Human Services (DHS), and to increase Indian Child Welfare grants to tribes and urban Indian agencies.

Capacity is needed for the AIW Unit to effectively address the alarming rates of American Indian children entering Minnesota's child welfare system. Additional staff are needed to:

- Develop and expand culturally-based prevention services for American Indian children and families
- Ensure the department has capacity to manage Indian child welfare program grants in accordance with statutory requirements
- Provide legal expertise, navigation and guidance on tribal/county jurisdictional issues, function as American Indian liaison between the judicial branch and department, and provide and/or coordinate judicial training and technical assistance to Children's Justice Initiative team, county and tribal attorney/judges policies, practices impacting American Indian children
- Respond to requests for case consultation to counties in timely technical assistance for improving outcomes of American Indian children and families, and implement regional mapping sessions intended to better understand deficits and create a community engagement model that can be utilized to build and maintain authentic, genuine relationships strengthening tribal/county partnerships
- Develop culturally-based responses and supportive policies to respond to sex trafficking and sexual exploitation of American Indian children and youth
- Convene and facilitate a workgroup to update the Tribal/State Agreement (TSA) for Indian child welfare
- Clear a multi-year backlog of practice and compliance complaints regarding county compliance with federal and state requirements involving American Indian children in the child protection system.

This proposal also recommends increasing the Indian Child Welfare grants (ICW)[1] by $4 million.

Rationale/Background:

Indian Children in the Child Protection System

American Indian and Alaska Native children, families and tribes endured multiple generations of family separation at the hands of federal, state and local governments. In the 1970s, studies revealed that 25 percent to 35 percent of Indian children were being removed from their homes, with 85 percent of those children placed in foster care

[1] See: Minn. Stat. § 260.785

away from their families and communities, even when fit and willing relatives were available.[2] Today, compared to white children, American Indian children experience a higher rate of involvement in the child welfare system. According to 2020 Minnesota child welfare data,[3] American Indian children:

- Have the highest rates of contact with Minnesota's child protection system.
- Are about five times more likely to be reported as abused or neglected than white children.
- Are 16.4 times more likely to experience foster care than white children.

Even though both state and federal laws have been enacted to address the rates at which Indian children are removed from their homes, data continues to show that Indian children are disproportionately overrepresented in the Minnesota child welfare system. Several contributing factors for ongoing disproportionality are: 1) failure to understand and correctly implement federal/state requirements and best practices, 2) lack of strategies to systematically address and reduce biases and, 3) the AIW unit's limited bandwidth to routinely provide guidance, consultation and supports to the multitude of systems delivering child welfare services impacting American Indian children and families.

This proposal would fund staff to develop collaborative strategies to address the long-standing chronic disproportionality for American Indian families by providing a culturally specific continuum of services in prevention and family preservation, foster care, adolescent services, adoption, kinship, and continuous quality improvement programs.

American Indian Child Welfare Prevention Consultants

The AIW Unit needs prevention-oriented staff to more robustly expand the department's prevention, preservation and early intervention work with American Indian families and tribes to meet the requirements of government-to-government consultation.[4] Currently, only one FTE is assigned to these tasks, which is inadequate and limits the department's ability to do this work. Additional capacity is needed to help local social services agencies in accessing the support services available, identify and meet training needs, provide case consultation and cultural guidance on prevention best practices, and deliver technical assistance designed to prevent out of home placement with an emphasis on American Indian communities. This new FTE will help the state advance prevention efforts in the American Indian community that may eventually be eligible for federal Title IV-E reimbursement.

Indian Child Welfare Grants Management

In 1999, the legislature appropriated $1.482 million through the Indian child welfare (ICW) grants to tribes, Indian organizations, or tribal social service agency programs located off-reservation. This funding assists programs that serve Indian children and their families to provide primary support services for child welfare programs; placement, prevention and family reunification services; and crisis intervention to promote family preservation through access and connectivity of culturally appropriate services. These resources are vital in advocating for Indian families who are impacted by county social services agencies' child welfare work and/or judicial court proceedings. There are three specific primary funding sources: Indian child welfare primary grants, special focus grants, and legal support services. Grant funding does not include administrative costs for grants management.

[2] For more information on the removal of Indian children from their families and tribal communities, see: Federal Indian Boarding School Initiative Investigative Report, May 2022

[3] See Minnesota's Out-of-Home Care and Permanency Report, DHS 2020 and Minnesota's Child Maltreatment Report, DHS 2020

[4] See Minnesota Statute, chapter 14, Article 11, section 5. https://www.revisor.mn.gov/laws/2021/1/Session+Law/Chapter/14/

Ten tribal communities[5] and five Indian urban agencies[6] receive grant funding allocated through 21 ICW grants established in accordance with Minnesota Statutes, section 260.785.[7] Currently, one full-time staff is managing 10 ICW grants while assisting with the broader work of the AIW Unit and acting as liaison to the American Indian Child Welfare Advisory Council. Another full-time staff manages 11 of the tribal grants. This same staff person is responsible for responding to complaint resolutions and county/tribal disputes (see below).

Additional staff are needed to ensure the department can manage ICW grants effectively, ensure compliance with grant requirements, and provide timely consultation to grantees.

In addition, the Indian Child Welfare grants provided to tribes and urban Indian agencies have not increased since the original legislation in 1995. At the 2022 Tribal Summit, the department was asked to increase the ICW Primary Grants by $4 million.

Human Trafficking – American Indian Response

American Indian children are disproportionately victims of sex trafficking or sexual exploitation. According to Social Services Information Systems (SSIS) data between June 2017 and April 2022, child welfare agencies in Minnesota received 2,335 reports of sex trafficking or sexual exploitation of children. Data indicates that there is an over-representation of children of color, in particular American Indian children, who are victims of sex trafficking or sexual exploitation. American Indian children were 6.2 times more likely than white children to be victims of sex trafficking or sexual exploitation (according to 2018 census population estimates). According to DHS data from June 2017 through April 2022, 13 percent of child victims in child protection sex trafficking or sexual exploitation investigations were Indian children (16 percent in sex trafficking investigations).

The AIW Unit needs additional staff to work collaboratively with tribal communities to develop and expand upon existing culturally based programs and resources that collaborate with tribal child welfare teams who identify and serve youth that are at risk or are being trafficked and/or exploited.

Additional staff will enable the department to develop technical assistance, provide case consultation, and design training for service providers, and state and county agencies for responding in a culturally appropriate manner to sex trafficking and sexual exploitation of American Indian children and youth.

Tribal State Agreement Updates

The Tribal State Agreement (TSA) is an agreement signed by the department's commissioner and the tribal chairpersons from the 11 tribal governments in Minnesota. The agreement reflects a comprehensive state-tribal agreement that reflects the working relationship between the department and each of the 11 tribes in Minnesota for the delivery of child welfare services to diminish duplicative services, and provide guidance around county/tribal relations and collaboration. The agreement outlines policies and procedures agreed to by tribes and the department, specifying the roles and duties of each in implementing child welfare services to Indian families and children.

The purpose of this agreement is to protect the long-term best interests of Indian children and their families by maintaining the integrity of tribal families, extended family and children's tribal relationships, as defined by the tribes. The concept of belonging is inherent to the best interests of Indian children; it is a reality for them only by recognizing the values and way of life of a child's tribe and supporting strengths inherent in social and cultural standards of tribal family systems. The foundation of the TSA is acknowledgement that Indian people understand

[5] Minnesota tribes that receive ICW grants: Boise Forte Band of Chippewa, Fond Du Lac Reservation, Grand Portage Band of Lake Superior Chippewa, Leech Lake Band of Ojibwe, Lower Sioux Indian Community, Mille Lacs Band of Ojibwe, Prairie Island Indian Community, Red Lake Nation, Upper Sioux Community and White Earth Nation.

[6] Ain Dah Yung Center, ICWA Law Center, Minneapolis American Indian Center, Minnesota Women's Indian Resource Center, and Northwest Indian Community Development Center

[7] See: Minn. Stat. § 260.785

the needs of their children and families, and that Indian children are the future of their tribes and vital to their existence.

The commissioner and tribal chairs originally signed the TSA in 1999, with amendments made in 2007. The department and the 11 tribes agree the TSA needs to be updated. Temporary staff will be needed to coordinate the work of updating the TSA.

Complaints and Ongoing Technical Assistance

As a part of the TSA, the department established a process of maintaining and monitoring county practices and compliance with state and federal laws established to protect American Indian children, families and tribes involved in the child welfare system. Additionally, a process for technical assistance to local agencies to improve compliance with state and federal laws and support best practices for working with American Indian children.

Allegations of noncompliance regarding a county agency can be made by any person, agency or entity that believes noncompliance has occurred through a formal submission of a complaint. The TSA requires that complaints be responded to within three days of receipt, followed by timely research, resolution, and robust technical assistance and training to counties to prevent future noncompliance.

Prior to 2016, the department received approximately one to three complaints each year. In 2016, DHS received 16 complaints. The number of complaints has steadily increased since 2016, averaging 30 complaints per year from 2017 to the present. One staff person in the AIW Unit is charged with responding to complaints received, while also managing 11 tribal grants, providing equity policy consultation, and serving as liaison to the ICWA Advisory Council.

This inadequate staffing level has resulted in a backlog of 120 complaints made since 2017 and gaps in ongoing supports have been identified in county/tribal relations around child welfare specific issues. Additional staff are needed to fulfill these important responsibilities with providing ongoing active and real-time guidance, consultation, engagement and building upon positive county/tribal relations. Additional staff will ensure the department can fulfill its obligation to Indian families and tribes by responding efficiently and effectively to complaints through the design and implementation of a county/tribal engagement framework. Additional staff will also ensure the AIW Unit can provide robust technical assistance and case consultation to counties to improve practice and compliance when working with Indian children, improve tribal relations when there is intersectionality as well as identify gaps in training and other barriers to positive authentic, genuine relationships with tribal and county relations.

American Indian Well-Being Attorney

The AIW Unit does not have an attorney with specialized experience in tribal/state laws and practices when concerns or issues arise regarding placement, reunification, adoption, kinship services and well-being for American Indian children under the American Indian Child Welfare Initiative (Initiative), non-initiative, and state court jurisdiction intersectionality. An attorney with this specialization is necessary to advise the agency when developing policy, procedures, and guidance to local agencies, as well as updating statutory provisions that affect Indian children and families. The state has an obligation to engage and consult with Minnesota's Indian tribes and urban Indian communities. Specialized legal knowledge is a key element in ensuring that such engagement and consultation is authentic and grounded in a recognition of tribal sovereignty.

Proposal:

This proposal would fund nine permanent and three temporary three-year, full-time positions in the American Indian Well-Being Unit.

American Indian Child Welfare Prevention Consultants – 2 FTEs

Currently, the department has one prevention services consultant working specifically to address services for Indian families. This proposal provides two additional prevention services staff to partner with rural and urban tribal communities throughout the state. These staff will expand development of culturally specific prevention services to ensure that they are compliant with FFPSA prevention program requirements and are integrated with existing prevention, and family preservation efforts. These positions would strengthen our partnership with staff in Behavioral Health and Development Disabilities Divisions and would enable further support, guidance and resources to be developed around Indian children receiving voluntary services. Other concerns that could be addressed include recruitment of Indian family foster parents, guidance on family preservation, rapid consultation and technical assistance to counties, and consultation with the 11 Minnesota Tribes and urban Indian communities and agencies.

Indian Child Welfare Grants – 2 FTEs

Currently, the department has two FTEs assigned to manage ICW grants and fulfill other duties. This proposal provides two additional full-time AIW Unit employees to manage ICW grants, assist tribal communities and urban tribal agencies more effectively and efficiently, and ensure compliance with grant requirements. Historically, inadequate staffing has affected the American Indian Well-Being Unit's ability to execute grant contracts in a timely manner in accordance with Chapter 16A. Additional staff would enable the AIW Unit to better meet statutory timelines, deliver technical assistance to tribes more quickly, and more robustly and authentically engage with tribal nations/communities and Indian urban agencies.

This proposal includes a $4 million increase in ICW Primary Grants.

Human Trafficking American Indian Response – 1 FTE

As of April 2022, the department has hired one staff through the Office of Victims grant funding working collaboratively with tribal nations and American Indian urban organizations to address the trafficking and exploitation of Indian children and youth. In order to continue and expand, this proposal establishes this as a permanent role, providing for long-term goal setting not achievable within short-term grant timelines set to end September 30, 2023. This position would create, in consultation with the Minnesota Department of Health, tribal-specific and culturally responsive child welfare policy and practice for responding to sex and labor trafficking and exploitation, as well as appropriate responses for youth missing from care which may increase the risk for trafficking and exploitation in American Indian children. This work will be specific to American Indian youth at risk of and/or experiencing trafficking and exploitation.

The department will be able to develop closer and long-term partnerships with tribal nations while collaboratively strengthening tribal child welfare agencies' ability to be responsive and collaborative with the support of a multidisciplinary team. This position will be strengthened by ongoing engagement with tribal communities as well as the American Indian Child Welfare Advisory Council. The position will also support and contribute to the ongoing work to improve communication to counties through technical assistance, guidance on culturally appropriate services available, and case consultation.

In addition, $1,000 is needed for travel expenses each year to adequately engage with communities across the state.

Tribal State Agreement – 1 FTE (temporary unclassified)

Currently, the department does not have staff with capacity to manage the lengthy consultation process required to update the TSA. This proposal provides one temporary (three years) unclassified position to coordinate, facilitate, and manage workgroups for engaging tribal, county and department representatives in a process to mutually agree upon updates to the TSA, including those necessary to make the TSA consistent with 2015 legislative changes to federal and state changes.

In addition, $1,000 is needed for travel expenses each year to adequately engage with communities across the state.

Complaints and Ongoing Technical Assistance – 3 FTEs + 2 FTEs (temporary unclassified)
Currently, the department has one FTE assigned part-time to respond to complaints related to how counties are providing services for American Indian families. This proposal provides three additional full-time AIW Unit employees to ensure DHS can respond to complaints, in a timely manner, offer real time case consultation and assist local county agencies in meeting federal and state requirements. These positions will also assist with relationship building and problem solving between tribes and counties; help develop and implement a change in practice to respond in a culturally appropriate manner; assist with continuous quality improvement based on best practices; and facilitate regional mapping sessions to better understand systemic challenges in meeting federal and state requirements. The work of these staff directly benefits Indian families and tribes who have submitted complaints by resolving them and assisting in the quality of county child welfare work with Indian children and families.

This proposal also provides two temporary three-year unclassified positions to respond to and eliminate the backlog of 120 complaints that have built up since 2017 due to inadequate staffing. Indian families, Tribes or agencies who have submitted a complaint at a minimum need notification and/or receive a resolution. Temporary staff would enable the AIW Unit to quickly and efficiently resolve and complete past submissions.

American Indian Well-being Attorney – 1 FTE
Currently, the department does not have an attorney specializing in American in law intersectionality with county/tribal practice. This proposal provides one staff attorney to represent the department on Children's Justice Initiative Indian child welfare committee work related to practice around child welfare matters impacting Indian children. This position will also lead development of standardized Initiative and non-initiative guidance for state courts, state attorneys, guardians ad litem, county social services agencies and others. Furthermore, this position would assist with direction and implementation of work with Initiative tribes on issues such as data sovereignty, review and provide guidance on written resources, manuals, bulletins, and forms specific to legal requirements, and provide legal advice on issues involving Indian children in the child protection system.

Operational support – 2 FTE
Additional budget and financial staff to support implementation of new initiatives, including increasing tribal consultation across the Children and Families Services administration.

Impact on Children and Families:

This proposal intends to have a direct impact on reducing the number of Indian children in out of home placement supporting county agency practice when working with American Indian children through a collaborative, non-blaming and shaming process inclusive of agencies, individuals and tribes impacted by the child welfare system. These positions would assist tribal agencies and county agencies in expanding or improving services for successful approaches or enhancement of social structures that increase family self-reliance and links with existing community resources. This will assist in keeping Indian children connected with their family and tribal community.

Equity and Inclusion:

This proposal creates an expansion of the AIW Unit so staff will be able to respond to counties, tribes, urban Indian communities and agencies, families, and others who are impacted by the social services system. Timely responses, strengthening of county/tribal relations and authentic engagement should help address inequities for Native Americans, and decrease their disproportionate overrepresentation in the Minnesota child welfare system.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

The proposed additional positions will enable department staff to timely execute contracts, increase county and tribal supports, and foster authentic engagement with tribes and urban American Indian agencies in the AIW Unit's ongoing efforts to provide guidance and technical assistance in meeting contract goals. This proposal will enable DHS to engage with Minnesota's 11 tribes to update the TSA, strengthen tribal relations, and support tribes in prevention, family preservation, and other services. An updated TSA will help ensure that counties are following requirements and engaged in best practices, including providing culturally specific services to Indian families.

Impacts to Counties:

During AIW Unit technical assistance, county staff have repeatedly indicated that technical assistance and consultation has benefitted their ability to make changes with practice around implementation of federal and state requirement and how they work with American Indian children and families. Ensuring the AIW Unit has capacity to provide technical assistance in a timely way will better ensure counties can make changes and improve practices when working with American Indian children and tribes.

IT Costs:

Not applicable.

Results:

This proposal will better ensure the AIW Unit can meet statutory timelines for grants and provide technical assistance to grantees in a timely manner. This proposal will allow the department to respond to complaints, clear a backlog of cases, some dating back to 2017, provide real time consultation around culturally appropriate responses and ongoing technical assistance. Funding a position to coordinate updates to the TSA will result in a refreshed agreement between the department and tribal communities that incorporates current culturally based child welfare services and practices that best meet the needs of Indian children and families, and acknowledges and respects tribal jurisdictional authority and sovereignty.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			5,988	6,242	12,230	6,477	5,949	12,426
HCAF					-			-
Federal TANF					-			-
Other Fund					-			-
Total All Funds			5,988	6,242	12,230	6,477	5,949	12,426
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	45	Increase in ICWA Grants	4,405	4,405	8,810	4,640	4,640	9,280
GF	12	Children and Family Services Admin	2,328	2,701	5,029	2,701	1,925	4,626
GF	REV1	Admin FFP @ 32%	(745)	(864)	(1,609)	(864)	(616)	(1,480)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
			14	14		14	11	

FY 2024-2025 Biennial Budget Change Item

Change Item Title: Workforce Sustainability for People who Live in Their Own Homes

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	7,956	21,784	26,950	34,996
Revenues	0	0	0	0
Other Funds				c
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	7,956	21,784	26,950	34,996
FTEs	**13**	**13**	**13**	**13**

Recommendation:

In response to unprecedented, catastrophic workforce shortages and aligned with the hard-fought rights of people with disabilities to live and work in their own homes and communities, the Governor recommends investments to increase the sustainability of the long-term care workforce.

This proposal invests $29.740 M in fiscal years 2024-25 and $61.946 M in fiscal years 2026-27. It includes the following provisions:

- Increasing rates for the Positive Support Service to better attract professionals to offer the service;
- Updating the competitive workforce factor for unit-based services in the disability waiver rate system;
- Aligning disability homemaker rates with the homemaker rates in the Aging programs to create parity between the services;
- Increasing the hourly limits for paid parents and spouses for Community-First Services and Supports (CFSS) and Consumer-Directed Services and Supports (CDCS);
- Expanding required labor market reporting required for disability services providers to include input from direct service professionals (DSPs);
- Expanding accessibility and outreach efforts of both the Disability Hub and Direct Support Connect;
- Expanding the HCBS Culture of Safety, an initiative aimed at decreasing critical incidents and improving employee retention; and
- Increasing funding for disability innovation grants.

Rationale/Background:

The disability service continuum has come a long way over the past 30 years. Not long ago, the only option for Minnesotans with disabilities was to live in segregated, remote institutions. Today, people with disabilities have service options to live in their own homes, maintain competitive employment, attend school with their peers, and to have careers, families, and dreams of their own. This progress took years of advocacy, including amplifying and organizing the voices of people with disabilities, litigation, federal legislation, and building a body of research and evidence-based practices. Progressive reforms included: Medicaid Home and Community-Based Waiver services; Free and Appropriate Education laws; the Americans with Disabilities Act; the *Olmstead* Supreme Court decision; and the federal home and community-based services settings rule. All of this progress is now in serious jeopardy, as the workforce shortage has reached crisis levels for direct support professionals.

Direct Support Professionals (DSPs) “are the backbone and beating heart” of the system of supports for people with disabilities. They are directly responsible for assisting people to live and fully participate in their

communities. They perform varied, sometimes complex and life-sustaining tasks, including: help with eating, bathing, dressing, cleaning, redirection, getting in and out of bed or a chair, walking, and transportation. Attracting and retaining DSPs has increasingly become a challenge. Low wages and benefits coupled with increasing inflation and rapidly increasing wages in other industries are making the problem worse. [1]

Many public sector rates and programs have not kept pace with the workforce needs of communities across Minnesota. In particular, reimbursement rates for services for people in their own, non-provider controlled homes, are substantially underfunded. As a result, wages for direct support professionals are too low to attract and retain the necessary workforce and people are facing loss of independence, economic stability, health, and basic human dignity. While job vacancies in Minnesota are at record highs across all sectors, healthcare and social assistance sectors have the most severe workforce shortages, with more than 52,000 vacancies in the fourth quarter of 2021. These vacancies increased by 66 percent in just one year. While many industries are able to adjust their business models and financial structures to accommodate changing economic and demographic conditions, providers of Medicaid services in the long-term care sector are unable to change prices to accommodate the wage increases needed to compete with other industries.

The state of Minnesota is committed to all Minnesotans including those with disabilities to live independently. The 2020 Legislature authorized Independent Living First law, affirming that it is the policy of the State that all adult Minnesotans with disabilities can and want to live and work independently (Minn. Stat. §2546B.4905, subd. 8). Independent Living laws require that DHS ensure disability waivers support the presumption that all adult Minnesotans with disabilities can and want to live independently. The law requires DHS to ensure that each adult waiver recipient be offered the opportunity to live as independently as possible before being offered corporate foster care or customized living services.

While the COVID pandemic has exacerbated the workforce challenges in human service and direct support professions, the shortage has been looming on the horizon for many years. Demographers and people who use services have been warning Minnesota of this likelihood, advocating for policy changes and funding to respond proactively. The State must act boldly to respond to the crisis, making up for lost time and forgone investments. Since long-term care programs are largely funded through government programs which have legislatively set rates and in most instances do not increase with inflation, Minnesotans in every corner of the state are counting on us to revitalize this indispensable workforce.

Proposal:

This proposal uses multiple strategies, including rate increases, family-centered modifications, and administrative capacity-building to target Minnesota's most critical long-term care workforce needs:

1. Increasing rates for Positive Support Services.

This proposal amends the Disability Waiver Rate System (DWRS) to align the Standard Occupational Classification (SOC) codes with a higher level of clinical professional to recruit more workers to provide this critical service. This will result in a rate increase of 22.3%.

Positive Support Services is a home and community-based service available on the disability waivers. The service is used to support providers and families who are working with individuals who exhibit challenging behavior by developing and monitoring person-centered, individually designed proactive plans. While the service is in high demand, it is underutilized due to the workforce shortage and difficulty in attracting clinicians with the required qualifications. Providers and lead agencies point to the low rates of the service as the main contributing factor to the shortage. Over the pandemic, there has been an increase in support needs for people, often children, who

[1] [1] Community Supports in Crisis: No Staff, No Services. Institute on Community Integration, University of Minnesota; Human Services Research Institute; National Association of State Directors of Developmental Disabilities Services. June 2022.

have complex behaviors, including aggression and co-occurring developmental disabilities and mental health conditions. Positive Support Services is an effective tool in working with these populations.

2. Increasing rates for unit-based services

This provision increases the rates for unit-based services by fully funding the competitive workforce factor (CWF) within the disability waiver rate system (DWRS) for unit-based services with programming and unit-based services without programming, effective January 2024 and upon federal approval. The CWF will then be automatically updated again January 1, 2026 and then every two years based on an analysis in the difference between DWRS framework wage values and typical wages paid to occupations competing for the same workers. This will result in an average increase of 3.2% across all unit-based services initially, and then is projected to increase services by 6.4% when updated January 1, 2026.

Unit-based services are delivered through disability waiver programs and support people residing in their own home, while retaining access to their community and competitive employment. In calendar year 2020, unit-based services supported over 10,000 people across Minnesota each month. These services are billed in 15-minute units, as opposed to daily units of service for people supported in provider-controlled residential settings. Providers and lead agencies have reported challenges with recruiting and retaining enough staff to provide unit-based services, especially in Greater Minnesota. This proposal will keep the wage component in unit-based services rates competitive, in order to incentivize supporting people in their own homes.

3. Increasing disability homemaker rates and adding inflationary updates.

This provision syncs the homemaker rate under the disability program to the equivalent rate under the programs supporting older adults. Creating parity between programs will also ensure that homemaker rates are regularly updated to reflect changes in the cost of providing this service. For disability program homemaker services, this will result in an average increase rate of 22.77% upon implementation on January 1, 2024, and another 24.08% January 1, 2026. This will have inflationary updates over time to align with proposed rate changes for programs serving older adults.

Homemaker is a service that enables a person to reside in their own home and is available through waiver programs that serve people with disabilities and older adults. Unlike the rates available under older adult programs, the rates for this service under the disability waivers have not increased since 2015. These rates also do not have a method of being updated to reflect increased costs of providing the service. This has led to challenges for lead agencies to attract enough providers to support the people who need this service. In fiscal year 2021, homemaker services through the disability waivers were used by over 11,000 people in Minnesota.

4. Increasing the limits for paid parents/spouses for CFSS and CDCS.

This provision increases the allowed hours a parent of a minor or spouse can be reimbursed to provide cares under Community First Services and Supports (CFSS) and Consumer Directed Community Supports (CDCS). Due to the limited number of staff available, parents and spouses have stepped in to provide many needed services for their family members with a disability. Currently, parents and spouses can provide no more than 40 hours per week of CFSS or CDCS services. This limit was temporarily increased as part of the COVID-19 pandemic response and helped many people meet their support needs. This proposal will allow parents and spouses to provide more hours of service to account for the absence of staff. This provision allows:

- For multiple parents providing services to their minor child or children, each parent may provide up to 40 hours of personal assistance services in any seven-day period regardless of the number of children served. They must not exceed 80 hours in a seven-day period.

- If only one parent is providing personal assistance services to a minor child or children, the parent may provide up to 60 hours of personal assistance services in a seven-day period regardless of the number of children served.
- If a spouse is providing personal assistance services, the spouse may provide up to 60 hours of personal assistance services in a seven-day period.

5. Expansion of Labor Market Reporting to include direct support professionals.

This provision expands the reach of labor market reporting to include surveying direct support workers themselves. Current reporting is centered on providers only. This reporting will bring the real-life experiences of the workers to the analysis and narrative. Since many HCBS workforce segments are largely comprised of women and Black, Indigenous, and People of Color communities, this proposal is also aimed to identify inequities and identify strategies to ultimately reduce economic injustice for everyone. This proposal includes funding for both policy and technical staff to support this expanded effort and technical assistance needs, funding for translation of the survey in multiple languages, and funding to build data storage that support longitudinal data collection.

Annual labor market reporting is currently required for providers of disability waiver services, elderly waiver services, alternative care, PCA/CFSS, home health services, home care nursing services, as well as financial management services for participants who self-direct their services. See Minn.Stat. §256B.4914, subdivision 10a, paragraph (g) and §256B.4912, subdivision 1a.

6. Direct Support Connect (DSC) & Disability Hub Equitable Access.

This provision improves accessibility functions in Direct Support Connect to diversify the applicant pool and improve Disability Hub data evaluation and outreach. While the Direct Support Connect has been a valuable tool for finding and recruiting new workers, improvements in accessibility can be made to attract a wider pool of applicants, such as those who speak English as a Second Language. Improving accessibility and outreach is a valuable tool in managing the workforce shortage. This provision includes the following:

- 1 FTE within the Disability Services Division to ensure The Disability Hub systems data evaluation and outreach that serves the whole system (providers, lead agencies, people, and families) and all communities across the state.
- 2 FTEs: a MAPE Level 14 to coordinate efforts and strategies to help ensure materials, tools align to needs and people using them; and a MAPE Level 11- to develop and maintain content- online and in print. A parttime contract to develop a guide and communications.
- A parttime contract to market Direct Support Connect and develop technology upgrades including offering it in multiple languages and developing and maintaining additional tools and trainings.
- Grant contracts to advocacy organizations to train people on tools/resources and to help people self-direct their workers.

7. Culture of Safety Expansion

This provision funds six FTEs to conduct systemic critical incident review processes statewide, support the creation of three new Regional Quality Councils to complement the current four in Minnesota, and provide compensation to lead agencies and providers who participate in these systemic incident reviews.

DHS began the HCBS Culture of Safety pilot project in May of 2019 to discover systemic influences that contribute to HCBS critical incidents. The Culture of Safety model uses process mapping and human factors debriefing to understand the ways in which the system contributed to an incident. Recommendations are then made to improve overall systemic safety and culture. The model does not replace licensing or other health and safety measures required by law. Due to the success of the pilot and ongoing workforce challenges, DHS proposes to expand the model statewide to improve safety and improve workforce culture. This model has been shown to not

only decrease critical incidents, but to also positively impact workforce retention as a result of the cultural workplace transformation it generates.

8. Community Innovations Workforce Grants.

Lastly, this proposal increases funding for disability innovation grants to address the workforce shortage using community-driven, culturally specific and responsive strategies. This proposal will add $4 million per biennium, which will slightly more than double the current appropriation of $3.9 per biennium.

DHS will prioritize culturally responsive workforce innovations in subsequent requests for proposals aligned with the overarching grant purpose to incentivize grantees to identify creative ways to better support competitive employment opportunities and integrated, independent living options for people with disabilities.

The 2015 Legislature authorized innovation grants to incentivize the community to innovate and pilot creative ideas to better support outcomes for people with disabilities. DHS launched the program in 2016 to achieve these outcomes effectively and efficiently. The grant program currently includes three programs: large grants ($50,000+), individualized grants (formerly micro grants), and employment provider transition grants (employment first related). See the Innovation grants awarded webpage for a list of grantees in prior rounds.

Impact on Children and Families:

This proposal positively will impact children and families across the state. Families are experiencing tremendous stress as they provide support functions they did not previously provide due to the workforce crisis, as well as the COVID-19 pandemic. During the pandemic, children with disabilities were barred access to critical education and supports that they normally would have received in school settings. For some, this meant a family member had to give up or reduce employment, adding financial stress for the entire family and interfering with critical early interventions that would normally improve outcomes.

Increasing rates for DWRS services and allowing direct support professionals to be reimbursed for hospital cares is anticipated to lead to increased wages for workers and improved access for both adults and children using waiver services. Disability waivers serve about 55,000 people each year. Of those, about 20% are between the ages of 0-24. Children are the fastest growing group of people who use disability waivers.

In addition, modifying CDCS and CFSS to increase the weekly hourly caps for parents will have a significant positive impact on children and families. Age correlates significantly with CDCS use and with the growth in use. Between about 2015 and 2019, the number of children using CDCS grew about 20% each year. Almost 70% of children on a disability waiver use CDCS, compared to 15% of all people on disability waivers. About 20% of people who use PCA (which will become CFSS) are 22 years of age and younger.

Tribal Consultation

Was this Proposal Identified as a Priority During Tribal Consultation Pursuant to Executive Order 19-24?

☒Yes
☐No

This proposal would further expand optional participation in the Culture of Safety HCBS Critical Incident pilot to other lead agencies, including Tribal Nations acting as lead agencies. Currently, Red Lake, White Earth, and Leech Lake have contracts with DHS to operate as lead agencies. White Earth is also a home care agency, but would not be impacted by the rate changes in this proposal.

Impacts to Counties:

This proposal is expected to better support lead agencies in sustaining a robust continuum of service options for people using long-term services and supports. Counties have raised concerns about homemaker rates for several years and are looking to the State to increase rates and expand flexibilities for waiver and home care services. In addition, counties are partnering with the State to address the growing number of people with complex behavioral health support needs getting stuck in emergency departments with no clinically therapeutic and safe transition options. Increasing the rate for positive support services is expected to support hospital decompression and compliment other short-term and long-term the strategies afoot.

Several counties currently participate in the Culture of Safety HCBS Critical Incident pilot: Hennepin, St. Louis and Blue Earth Counties, Dakota, Olmsted, Clay, Polk, and Ottertail. This proposal would further expand optional participation from other lead agencies, including Tribal Nations acting as lead agencies and counties.

Equity and Inclusion:

The provisions in this proposal would impact people with disabilities receiving either home care or home and community-based waiver services. People who use the HCBS waivers also reflect Minnesota's wider diversity. In 2021, 32 percent of people on CAC, CADI, and BI waivers and about 19% of people on the DD waiver were people of color or American Indian.

Along with the impacts to people receiving services, it is expected that these proposals would impact the direct support professionals who provide services to this population. Skilled caregiving for people with disabilities and older adults is an equity issue.[1] "The intersections of gender, race, and immigration status are reflected in the defining characteristics of direct care workers. A significant majority of DSPs are women, who are often single mothers who frequently hold more than one job to survive financially, but who are still living in poverty or near poverty. (Hooyman, 2014)

While DHS does not have data to illustrate DSP worker demographics, National Core Indicators data (2020) indicates that approximately 70% of the DSP workforce are women, most of which are primary wage earners and head of households (Hewitt et al., 2021). Compared to general population data, the direct support workforce is disproportionately comprised of Black, Latinx, and other people of color (NCI, 2020). An increasing number of DSPs are first-generation Americans, who speak fluent English in addition to their language of origin and previously held health care positions in their country of origin (President's Committee on People with Intellectual Disabilities [PCPID], 2017).

IT Related Proposals:

The Positive Support Services rate increase, homemaker provision, and increasing limits for CDCS/CFSS will require MMIS edits. Updates to the CWF for unit-based services impacts 12 frameworks that will need to be updated in MnCHOICES by December 2024, and every two years thereafter. The DSC provision includes systems costs to translate and publish information on Direct Support Connect in multiple language.

Results:

Culture of Safety

The investments made into Minnesota critical incident response infrastructure via the Culture of Safety effort is expected to result in a number of system improvements and promoting a positive work culture, leading to fewer critical incidents involving people with disabilities and increase job retention for direct support workers.

Positive Support Service Rate Increase

The investments made to the positive support service are expected to increase the number of professionals providing the service, leading to shorter wait lists for service and a higher quality of care.

Updates to the CWF for unit-based services
DHS currently monitors utilizations for disability waiver services at the county level. If this proposal were passed, DHS would monitor whether there was increased use of unit-based services and where this was occurring.

Aligning disability homemaker rates with homemaker rates in the Aging programs
DHS currently monitors utilizations for homemaker services at the county level. If this proposal were passed, DHS would monitor whether there was increased use of this service and where it was occurring.

Increase limits for paid parents/spouses for CFSS and CDCS
This proposal is expected to increase the number of hours parents and spouses provide CFSS and CDCS services, filling a critical gap in service delivery due to the workforce shortage.

Expansion of Labor Market Reporting to include DSP
This proposal is expected to harness the feedback and input of direct support professionals, adding a robust layer of data to DHS' labor market reporting efforts and providing insights into DSP compensation, background and employment outlook.

Disability Hub and Direct Support Connect
This proposal is expected to increase the Department's ability to reach prospective Direct Support Professionals of diverse backgrounds, as well as people receiving services.

Fiscal Detail:

Summary of proposal fiscal components

Proposal Component	Component Detail	FY 24	FY 25	FY 26	FY 27
1) Culture of safety expansion	Annual contract costs of $80k and 6 FTE MAPE 11L	564	637	637	637
2) Positive support rate increase	22.3% rate increase Jan. 1, 2024.	84	807	1,054	1,064
3) DWRS Unit Based Service Competitive Workforce Factor (CWF)	CWF adjustment Jan. 1, 2024, January 1, 2025, and every two years after, 3.5% increase to unit based rates	1,382	7,982	11,988	19,947
4) Disability homemaker rates alignment and inflationary adjustments	Average rate increase 20.8% Jan. 1, 2024, and 24.7% Jan. 1, 2025.	2,271	5,667	6,291	6,560
5) Increasing the limits for paid parents/spouse of CFSS and CDCS	Increase average monthly costs of qualifying individuals CFSS and CDCS by 6%.	653	3,427	3,657	3,716
6) Supporting people with disabilities and direct support professionals during hospitalizations (placeholder)	Placeholder item awaiting report.				
7) Direct support professionals labor market reporting expansion	Survey translation costs $3k, Systems cost $77k initially and $15k ongoing annually, and 3 MAPE 14L FTE	351	327	327	327
8) Direct Support Connect and Disability Hub equitable access	$250k advocacy organizations grants, Disability Hub contract, communications and material translations contract, and 1 MAPE 14L and 1 MAPE 11L FTE	471	728	787	537
9) Community innovations workforce grants	Expand innovation grant funding by $2 million annually and 2 MAPE 14L FTEs	2,180	2,208	2,208	2,208
Total		**7,956**	**21,783**	**26,949**	**34,996**

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			7,956	21,784	29,740	26,950	34,996	61,946
HCAF								
Federal TANF								
Other Fund								
Total All Funds			7,956	21,784	29,740	26,950	34,996	61,946
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	14	Culture of Safety Admin FTEs 6	749	857	1,606	857	857	1,714
GF	14	Admin (Culture of Safety contract)	80	80	160	80	80	160
GF	REV1	Admin FFP @ 32% (Culture of Safety)	(265)	(300)	(565)	(300)	(300)	(600)
GF	33	MA LW - Positive Supports	84	807	891	1,054	1,064	2,117
GF	33	MA LW - DWRS CWF Unit Based	832	7,982	8,814	11,438	19,947	31,385
GF	11	Systems MnCHOICES- CWF Unit Based	550	0	550	550	0	550
GF	33	MA LW DW Homemaker Parity	2,271	5,667	7,938	6,291	6,560	12,851
GF	33	MA LW -Parents & Spouses	489	2,571	3,060	2,743	2,787	5,530
GF	33	MA ED -Parents & Spouses	157	823	979	878	892	1,770
GF	34	Alternative Care - Parents & Spouses	7	34	41	37	37	74
GF	14	Admin - ADSA Labor Market	401	459	860	459	459	918
GF	Rev	Admin FFP @ 32% (Labor Market)	(127)	(147)	(274)	(147)	(147)	(294)
GF	11	Systems Costs - Labor Market	77	15	92	15	15	30
GF	14	ADSA Disability HUB	133	153	286	153	153	306
GF	REV1	Admin FFP @ 32% (Disability HUB)	(34)	(38)	(72)	(38)	(38)	(76)
GF	14	ADSA Admin - Direct Support Connect	547	901	1,448	621	621	1,242
GF	55	Disability Grants - Direct Support Connect	0	0	0	250	0	250
GF	REV1	Admin FFP @ 32% (Direct Support Connect)	(175)	(288)	(463)	(199)	(199)	(397)
GF	55	Disabilities Grants - Innovations	2,000	2,000	4,000	2,000	2,000	4,000
GF	14	ADSA Admin - Innovations	265	306	571	306	306	612
GF	REV1	Admin FFP @32% (Innovations)	(85)	(98)	(183)	(98)	(98)	(196)
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	14	ADSA Admin	13	13	13	13	13	13

Statutory Change(s):

This proposal will require a number session laws, riders, and statutory changes: 256B.4914, 256S.2101, 256B.211, 256B.4911, and 256B.85.

Change Item Title: Data-Based Rates for Residential and Own-Home Disability Services

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	8,858	68,313	77,795	122,819
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	8,858	68,313	77,795	122,819
FTEs	**0**	**2**	**2**	**2**

Recommendation:

The Governor recommends investments of $77.2 million in fiscal years 2024-25 and $200.6 million in fiscal years 2026-27 to support the sustainability of residential services and home and community-based services provided to people with disabilities. This proposal includes: (1) updating the rate methodology for intermediate care facilities for persons with developmental disabilities (ICF/DD) and (2) updating the data used to rebase rates funded by the Disability Waiver Rate System (DWRS).

Rationale/Background:

Minnesota is currently experiencing an unprecedented workforce shortage in the long-term care sector. While job vacancies in Minnesota are at record highs across all sectors, healthcare and social assistance sectors have the most severe workforce shortages, with more than 52,000 vacancies in the fourth quarter of 2021. These vacancies increased by 66 percent in just one year. While many industries are able to adjust their business models and financial structures to accommodate changing economic and demographic conditions, providers of Medicaid services in the long-term care sector are unable to change prices to accommodate the wage increases needed to compete with other industries. This proposal provides rate increases to assist disability service providers in competing with other industries for staffing.

ICF/DD Rate Methodology

An intermediate care facility for persons with developmental disabilities (ICF/DD) is a licensed supervised living facility. These facilities provide services to people who have developmental disabilities or related conditions. There are currently ICFs/DD in 58 Minnesota counties and range in size from 4 to 64 persons. Prior to the development of home and community-based waiver services, all Medicaid services to a person with a disability had to be delivered in an institution, such as an ICF/DD. Since the introduction of Developmental Disability (DD) waiver in Minnesota, the number of people receiving ICF/DD services has steadily declined. Several initiatives were put in place to encourage the use of home and community-based services and decrease demand for ICFs/DD, including a rate freeze on the per diem rates for each facility in the early 2000s. Since that time, providers of ICF/DD services have received some general rate increases and some individual rate increases based on their county of service from the legislature. Providers continue to submit cost reports to the Department and have continued to report that revenues have fallen short in covering the costs of their services.

Disability Waiver Rate Framework Increases

The Disability Waiver Rate System (DWRS) is Minnesota's uniform, statewide methodology to determine reimbursement rates for home and community-based services provided under the four Medicaid (MA) disability waivers—the community alternative care (CAC) waiver, the community access for disability inclusion (CADI) waiver,

the developmental disability (DD) waiver, and the brain injury (BI) waiver. The 2013 Legislature enacted the DWRS and it was implemented beginning on January 1, 2014. In fiscal year 2021 there were over 55,000 people who used disability waiver services. Waiver services are reimbursed using three payment structures: framework services, market rate services, and pre-determined rates. Framework rates include: adult day services, community residential services (CRS), customized living, day support, employment development, employment exploration, employment support, family residential services (FRS), integrated community supports (ICS), individualized home supports (IHS) with and without training/family training, night supervision, positive support services, prevocational services, and 15 minute respite.

Prior to January 1, 2014, each county and tribe negotiated rates and entered into contracts with providers offering services in their geographic area. Now, framework rates are set by the state using the DWRS. The DWRS rate framework takes into consideration the following items: (1) supervision costs; (2) staff compensation; (3) staffing and supervisory patterns; (4) program-related expenses; (5) general and administrative expenses; and (6) intensity of recipient needs. An individual's service needs, as determined by an assessment, are the basis for calculating rates under the DWRS. Services reimbursed under DWRS are categorized into four service types: (1) residential support services; (2) day services; (3) unit-based services with programming; and (4) unit-based services without programming—each with a different rate calculation formula. The reimbursement rate for each type of service includes factors related to that service type and personalized factors such as the staffing ratio and the units of service (i.e. 15 minutes, an hour, a day) needed. The calculations also include an adjustment factor for people assessed to have higher support needs based on being deaf or hard-of-hearing and a competitive workforce factor.

Staffing costs are determined using a base wage index that is automatically adjusted for inflation every two years. Current law provides the next change to DWRS rates on November 1, 2024, using the Bureau of Labor Statistics (BLS) Wage data available Spring 2021. Other framework components used in calculating rates include items such as: (1) supervisory span of control ratio; (2) employee vacation, sick, and training allowance ratio; (3) employee-related cost ratio; (4) general administrative support ratio; (5) program-related expense ratio; and (6) absence and utilization factor ratio. Certain framework components are also adjusted for inflation every two years. Current law changes rates November 1, 2024, using data available December 31, 2021, as well as future increases starting July 1, 2026, and every two years after for data available 30 months and one day prior to the scheduled update.

Since DWRS rates are updated using older data they have not kept pace with inflation. Since these services are almost exclusively funded by public dollars and since the rates are set in law and can only be adjusted through the legislature, it is imperative that the State move quickly to increase rates to ensure parity with services that utilize a similar labor pool, so providers can offer equitable compensation and retain current workers.

Proposal:

ICF/DD Rate Methodology

Effective January 1, 2024, or upon federal approval, whichever is later, the Governor proposes moving ICF/DD services to a single rate via phased implementation of a rate floor. This proposal would create an initial rate floor of $260 per day for ICF/DD services. All facilities with rates beneath the rate floor would rise to the floor value in 2024. At this time, the rate floor would increase the rates of approximately 29 facilities – providing a rate increase of amounts between $3 per person, per day to $140 per person, per day.

The $260 initial rate floor was determined after analyzing the costs of all ICF/DD providers in Minnesota, including their current daily rate and their cost reports. After comparing the effects of various rate floors, $260 is being proposed to stay within the range of forecasted spending while maximizing the number of providers who will see increased rates. Additionally, this proposal will continue to keep Minnesota in compliance with federal rules for ICF/DD reimbursement upper payment limits.

This proposal does not include any changes to the rates for other ICF/DD related services. If the daily rate is not adequate for the person's individual needs, ICF/DD providers may continue to request an additional variable rate

to support the person's documented increased needs. Additionally, people living in ICFs/DD can continue to receive and ICF/DD providers can continue to be reimbursed for services provided during the day (as an alternative to the person attending a day training and habilitation program). The variable rates and services during the day rates will not be affected by the proposed rate floor. Beginning January 1, 2024, and every two years thereafter, the rate floor would increase based on inflationary changes measured by the consumer price index. Over time, more and more facilities would receive rate increases each year until, eventually, Minnesota would pay a single statewide rate for ICF/DD services. Once the single rate was achieved, all facilities would have rates adjusted each year to account for inflation.

This approach ensures that facilities with the lowest rates receive support the quickest. This proposal also achieves a statewide service rate without negatively financially impacting providers while the transition occurs.

Inflationary Updates for Disability Waiver Rate Framework

Effective January 1, 2024, or upon federal approval, whichever is later, the Governor proposes adjusting the timing of disability waiver rate framework (DWRS) inflationary updates and the data used for the updates.

This proposal adds a new inflationary adjustment period on January 1, 2024, using data the May 2021 BLS SOC code data available spring 2022 and Consumer Price Index (CPI) data available on December 31, 2022. The proposal also moves the next inflationary adjustment to January 1, 2026, using BLS wage May 2023 dataset, available spring 2024, and CPI data that is available twenty four months and one day before the adjustment. Ongoing, adjustments will occur every 2 years using BLS data published 2 years from the previous dataset used for updates and CPI data that is available twenty four months and one day before the adjustment.

Below is a summary of the change:

	Current Law	Proposed
Timing of when adjustments occur	11/1/2024, 7/1/2026, and every two years thereafter	1/1/2024 and every two years thereafter
Wage data used (BLS)	Data published 2.5 years prior	Data published 1.5 years prior
Inflationary data used (CPI)	11/1/2024 update considers two years of CPI changes (12/31/2019-12/31/2021) Ongoing adjustment considers two years of CPI changes.	1/1/2024 update considers three years of CPI changes (12/31/2019-12/31/2022) 1/1/2026 updates considers one year of CPI changes (12/31/2022-12/31/2023) Ongoing adjustment considers two years of CPI changes.

This proposal also includes compensation thresholds that require providers to use a specified minimum percentage of revenue generated from rates for direct support professional compensation.

Impact on Children and Families:

Children receiving long term services and supports may likely be impacted by these changes. Data available in January of 2021 showed that 11.8% of individuals receiving long-term services and supports were age 15 or under and another 7.8% were between the ages of 16 and 24. Looking solely at Home and Community Based Services, 13% of participants were under the age of 15 and another 8.5% were between the ages of 16 and 24. This proposal will provide resources and tools to allow providers to better support all people with disabilities receiving long-term services and sup ports, including children and youth.

Equity and Inclusion:

ICF/DD Rate Increase

This proposal would increase the likelihood that ICFs/DD programs would remain fiscally solvent, which would impact approximately 700 people with developmental disabilities by allowing them to remain in ICFs/DD programs if it is their choice to do so. Most people receiving ICF/DD services have resided in these facilities for many years and are now older adults. Most people that access ICF/DD services (92%) identify as white, which is higher than the overall population of people who access long-term services and supports (79.1%).

In addition to supporting people with developmental disabilities, the proposal also increases equity among providers. With the current rate structure, providers must lobby individually to increase their unique daily rate in statute and this practice can be more difficult for smaller, rural providers. The proposal increases equity across providers, regardless of size or location.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

This proposal does not have a substantial direct effect on one or more Minnesota Tribal governments.

Impacts to Counties:

The increase in ICF/DD rates will impact some counties which are responsible for 10% of the cost of ICF/DD services. Currently, counties must cover 10% of the cost of placements that exceed 90 days in Intermediate Care Facilities for Persons with Developmental Disabilities which have seven or more beds, in accordance with Minn. Stat. §256B.19, subd. 1, (3).

Additionally, counties have expressed concern about the workforce shortage and challenges that providers are facing in attracting and retaining staff. This proposal seeks to increase the availability of staffing for the people served.

IT Costs:

This proposal requires systems changes to MnChoices and MMIS.

Results:

This proposal will result in an increase to service rates, which in turn is likely to lead to increased staff wages and improved recruitment and retention.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			8,858	68,313	77,171	77,795	122,819	200,614
HCAF								
Federal TANF								
Other Fund								
Total All Funds			8,858	68,313	77,171	77,795	122,819	200,614
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	33	MA LW - DWRS	7,283	64,540	71,823	73,761	118,597	192,358
GF	33	MA LW – ICF/DD	1,566	3,650	5,216	3,830	4,025	7,855
GF	11	Systems - MMIS	9	2	11	9	2	11
GF	14	Auditors Admin (0,2,2,2)	0	178	178	286	286	572
GF	REV1	Admin FFP @ 32 %	0	(57)	(57)	(91)	(91)	(182)
					0			0
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	14	ADSA Admin	0	2		2	2	

Statutory Change(s):

256B.5012, 256B.4914, 254D

Change Item Title: Critical Access Nursing Facilities

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	913	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)	913	1,000	1,000	1,000
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends an investment of $1.9 million in the FY24-25 biennium and $2 million in the FY26-27 biennium to designate certain nursing facilities in non-metro areas as critical access facilities and provide a temporary supplemental payment to these designated nursing facilities. This recommendation increases the existing funding by $1 million per year to help rural nursing facilities with a supplemental payment to get them through the temporary period of time it will take for the increased expenditures to be reflected in their future rates.

The funds are recommended to assist rural nursing facilities by improving their financial stability and keep their doors open to ensure access to nursing facility care for residents residing in deeply rural and outstate Minnesota. This proposal represents a 0.18 percent change relative to the overall Nursing Facility Rates and Policy (NFRP) budget.

Rationale/Background:

This proposal is intended to address the financial viability of rural nursing homes at risk of closure in order to maintain access to nursing facility care within a reasonable distance from resident's homes and family. Rural nursing facilities in MN (and nationally) have been especially affected by severe staffing shortages due to COVID-19. Facilities are faced with increased staffing costs when staff are secured, and oftentimes must limit new resident admissions, thereby decreasing occupancy. At times, the staffing shortages are so severe that it forces rural nursing facilities to close. MN Dept. of Health staffing shortage tracking confirms that rural facilities are struggling with staffing issues and inquiries to NFRP from rural facilities about how they might improve their staffing and cash situations are increasing. All the funds sought for this proposal will be used to support the intervention.

The legislative authority for designating a Critical Access Nursing Facility (CANF) still exists currently in law and the funding associated with the program ($1.5 million per year) under current law has not been suspended. The increases in costs to nursing facilities since COVID-19 and the financial distress in rural nursing facilities has prompted a look at restarting CANF, but with modifications for determining supplemental payments due to implications with value-based reimbursement (VBR).

Proposal:

This proposal revamps and revitalizes an existing program for nursing facilities that was rendered obsolete (and thus hasn't been administered) since the beginning of the Value Based Reimbursement (VBR) payment system in 2016. The restructured CANF program would have the ability to assist an estimated 15 rural nursing facilities by

providing an increase to their daily rates. This would result in approximately $332,000 of new revenue per year for an average 50 bed facility participating in the CANF program. This will impact approximately 550 people annually living in rural communities seeking this type of health care. The overall intent is to assist in ensuring rural, especially deep rural residents, have access to nursing facility care within a reasonable radius from their homes.

With this reinstatement and reinvention of the CANF program, there will be necessary adjustments to the criteria that factors in how the supplemental payment is recognized in the VBR payment system. It will impact a forecasted program (Medical Assistance (MA) rates to nursing facilities). The effective implementation date of this proposal is July 1, 2023.

DHS will revise the old CANF application form and materials and publish a request for proposals from eligible providers. Applications will be reviewed, and determinations made on a timeline to allow supplemental CANF payments to begin effective July 1, 2023.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:

There is a minimal fiscal impact to counties with this proposal in that they pay for a very small portion of nursing facility care for people under 65 years of age.

This proposal will positively impact counties in rural areas of the state. In counties with very few nursing facilities (e.g. Cook and Hubbard), access to the one nursing facility in the county is very important.

IT Costs:

This is not an IT specific proposal and there are not any systems related costs associated with implementation of the proposal.

Results:

This recommendation revises the CANF program that has been temporarily suspended, and which requires modification from the previous program to make it compatible with VBR. Eligible facilities will be selected through a competitive process. Designated facilities would be eligible for a rate add-on for a period of up to two years. Designation of eligible facilities and associated rate add-ons will be within the limits of funds appropriated for this purpose. DHS NFRP tracks the number of rural nursing facility closures annually. With the implementation of this proposal we will continue to track rural facility closure rates, and, track the annual closure rates of the facilities that receive the CANF funds to measure if the rate of closure is lower for rural facilities that receive this special and time-limited CANF funding.

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of nursing facilities receiving approval for the payment	0				January 2025 and annually thereafter
Results	How many nursing facilities that received the supplemental payment remained open and how	2021 – 4 rural NFs closed.	Years 2014 through			Annually beginning June 2025

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
	many closed. How many nursing facilities that applied for and did not receive the supplemental payment closed and how many stayed open.	2022 - Pending	2021, average annual closures – 3.4 NFs			

Rural challenges/Medicaid reform

The following links are to resources that discuss and present data regarding the financial challenges rural nursing facilities face and how these can lead to facility closures which in turn can create access issues. These sources suggest that Medicaid reimbursement changes are a needed part of the solution.

https://digitalcommons.library.umaine.edu/cgi/viewcontent.cgi?article=1848&context=mpr

https://rupri.public-health.uiowa.edu/publications/policybriefs/2021/Rural%20NH%20Closure.pdf

https://www.minneapolisfed.org/article/2021/pandemic-renews-fear-of-nursing-home-closures-in-ninth-district

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			$913	$1,000	$1,913	$1,000	$1,000	$2,000
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$913	$1,000	$1,913	$1,000	$1,000	$2,000
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	33		$913	$1,000	$1,913	$1,000	$1,000	$2,000
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Changes:

MS 256R.47

Change Item Title: Planning for Innovative Workforce Solutions

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	835	1,064	208	208
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	835	1,064	208	208
FTEs	**4**	**4**	**3**	**3**

Recommendation:

The Governor recommends $1.9 million in FY24-25 and $416,000 in FY26-27 for leveraging community wisdom and Medicaid flexibilities to plan for long-term solutions that address the ongoing workforce crisis for people with disabilities and people with high behavioral support needs. This proposal invests in the following:

1) Administrative resources to study and develop recommendations that expand access to several waiver services, including: positive support, crisis respite, respite, and specialist services; and
2) Administrative resources to develop and implement a curriculum and training plan to ensure all lead agency assessors and case managers have the knowledge and skills necessary to fulfill support planning and coordination responsibilities for people who use home and community-based services.

Rationale/Background:

The workforce shortage has reached crisis levels in Minnesota, with job vacancies at record highs across all sectors. The hardest hit economic sectors are healthcare and social assistance, with 52,340 vacancies in the fourth quarter of 2021. [1] The number of Minnesotans turning 65 in this decade (about 285,000) will be greater than the past four decades combined. The total number of older adults (65+) is anticipated to double between 2010 and 2030.[2] By then, more than 1 in 5 Minnesotans will be an older adult. Compounding the sweeping workforce shifts, disability and conditions that necessitate the need for independent living supports become more prevalent as people age. While 9% of individuals between the ages of 18-64 have a disability, the percentage of individuals with a disability nearly quadruples to about 34% for people ages 65-84. [3]

While increasing reimbursement rates is an important tool to increase wages and attract workers, the sheer magnitude of demographic shifts will require the State to employ a range of creative, community-driven solutions that expand access, re-envision possibilities for people, and pave pathways for natural supports. Nationally, the number of working age people entering the workforce is not keeping pace with the increased demand for long-term services and supports. Several demographic factors are influencing this decline, including a slower growth rate in the overall population, more of the U.S. population entering retirement years — and needing support — and an overall decrease in the percentage of the population participating in the labor force.

According to Minnesota State Demographer, Susan Brower, the current workforce crisis is destined to get worse. Projections show that by 2040, if our state is to experience any population growth at all, it will be from migration.

[1] https://mn.gov/deed/data/data-tools/job-vacancy/jvs-findings.jsp
[2] https://mn.gov/admin/demography/data-by-topic/aging/
[3] https://www.mncompass.org/data-insights/articles/7-things-know-about-minnesotas-older-adults

In the coming decades, Minnesota's population and its workforce will become increasingly older, and growth in the labor force will slow dramatically as a result. In the next five years, Minnesota is expected to reach the point where we have 1 older adult for every 3 adults of working age. A decade ago, that ratio was 1 for every 5. In addition, older adults are much more likely to have a health condition that makes it difficult to live independently. While about 1 in 14 Minnesotans under 65 have a disability, that figure rises to 1 in 5 for Minnesotans ages 65-74; 1 in 3 for those 75-84; and 2 in 3 for those 85 and older.[4]

These demographic shifts will continue to have a widespread impact on Minnesota's health and human service system, forcing us to not only fund systemic reforms, but also to manifest informal, community-driven support networks. In disability services, the term "natural supports" is a broad descriptor for unpaid or informal supports. These supports are often provided by friends, family, neighbors, and allies. To move from a support paradigm with a predetermined array of services to a more person-centered focus, we must recognize the person with disabilities embedded within their family system and within the community that they live (Amado, Stancliffe, McCarron, & McCallion, 2013). This means that public policy interventions should reconceptualize supports and their use beyond formal service systems.

Proposal:

This proposal invests in the following three innovative, workforce strategies:

1. ***Study and develop recommendations to expand access to several waiver services, including: positive support, crisis respite, respite, and specialist services.***

This study would examine existing intervention waiver services, as well as related state plan and behavioral health services and explore options to expand access under the 1915(i) authority. The study will culminate in a report to the legislature, including recommendations for next steps. DHS will engage stakeholders in developing recommendations. Stakeholders will include: children and adults with disabilities; people using intervention services; people who qualify for intervention services but are struggling to gain access to them; people who might benefit from intervention services, but do not currently qualify for them; parents and legal guardians; intervention service provider; metro and rural tribal and county lead agencies, and others. Stakeholder outreach will be offered in multiple languages. The selected vendor(s) will be required to use a variety of formats to reach stakeholders, such as written, video, in-person and electronic communication channels.

Gaps exist within the disability service system to address challenging behaviors across diagnoses, across the life span, and across different payment mechanisms. Hospitals and lead agencies trying to help people return to the community or find the most appropriate treatment option have reported that they cannot find service providers or that the people they work with are not eligible for certain disability waiver services known as "intervention services." Intervention services include crisis, emergency crisis, positive support services, and specialist services.

Expanding these services to a different MA authority, 1915i, could decrease the number of people placed in out-of-home crisis settings (hospitals, jails, crisis residential homes, treatment facilities), decrease the use of emergency response services that function as intervention services, add regional capacity to areas in Minnesota that lack intensive intervention and potentially decrease the number of adults and children with disabilities and complex behavioral needs being incarcerated.

Among working-age adults, the shift toward HCBS has, until recently, primarily involved populations with intellectual or developmental disabilities (ID/DD), rather than those with behavioral health needs. Social Security Act Section 1915(i), created in 2005 and amended in the Patient Protection and Affordable Care Act (ACA), gave Medicaid programs additional flexibility in approaching HCBS, including through providing services and supports to adults with behavioral health needs. Section 6086 of the Deficit Reduction Act of 2005 added Section 1915(i) to

[4] https://www.mncompass.org/data-insights/articles/7-things-know-about-minnesotas-older-adults

the Social Security Act, giving states the option to cover HCBSs without obtaining a 1915(c) waiver. Unlike 1915(c), the new 1915(i) option let states serve people who did not require an institutional level of care. Minnesota currently has two 1915(i) MA services: Housing Stabilization Services and Community First Services and Supports (partial authority to cover certain populations; currently pending CMS approval).

2. Develop and implement a curriculum and training plan to ensure all lead agency assessors and case managers have the knowledge and skills necessary to fulfill support planning and coordination responsibilities for people who use home and community-based services.

The development of lead agency assessor and case management training curriculum is a continuation of current efforts that include, the development of a support planning curriculum for case managers and assessors. This provision aligns with efforts to improve competency and onboarding of case managers. It would complement existing efforts to develop a cultural competency training series that would promote equitable access to support and services.

Funding for this provision will provide necessary resources to develop support planning and coordination competencies. The development of this training would support needs identified by the advocates, people, families, providers, and lead agencies. DHS will contract with a third party with expertise to support this work. This proposal will ensure the development of a standardized training curriculum for all disability waiver case managers. It will support consistency and equity in a person's experience with receiving waiver services and support.

Impact on Children and Families:
Children and families are anticipated to be positively impacted by this proposal. Intervention services, such as crisis, crisis respite, positive supports, and positive supports services are designed to support children with disabilities, behavioral health needs, and co-occurring disorders. They are also aimed to support children's families. These services prevent children (and adults) from needing higher cost, less-integrated institutional or residential settings and they help people step down from institutional or residential settings and return to the community/family homes. These services help parents to communicate with their child(ren), maintain supportive environments, and manage challenging behaviors.

The outcomes of this study, coupled with stakeholder input, will align with efforts underway including, child welfare policies and multiple Olmstead Plan goals. The findings of a study to simplify and expand intervention services would provide insights to bridge service gaps for children with co-occurring mental health and/or intellectual developmental disabilities who engage in severe physical aggression toward self and others. The stakeholder work to re-envision the future of disability services will explore ways that children and families can continue to access services considering the workforce shortage. Findings might help to:

- Increase positive impacts to maintain family unity which aligns with child welfare policies;[5]
- Reduce reliance on emergency response services to address challenging behaviors, aligning with Olmstead Plan goals; [6]

[5] Minnesota Department of Human Services: Children and Family Services. Minnesota's Out-of-home Care and Permanency Report, 2020. Available at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5408Ma-ENG. Accessed July 22, 2022.

[6] Minnesota Olmsted Implementation Office. Crisis Services Goals. Available at https://mn.gov/olmstead/plan-goals/crisis-services/. Accessed July 20, 2022.

- Maintain and enhance child, youth, and family connections to their desired school, community and family relations;[7] [8] [9]
- Prevent children with disabilities and physically aggressive behavior from being unnecessarily placed in juvenile detention;[10] [11]
- Support children and youth with disabilities and behavioral health support needs to remain in their homes, prevent unnecessary referrals to residential/institutional levels of care, and create step-down options for residential/institutional levels of care; and
- Support and empower parents and caregivers to build skills that support their child's disability-related needs in ways that increase family quality of life and promotes stabilization and permanency.[12] [13] [14]

Ensuring children, youth and families have access to all services considering the workforce shortage as well as early intervention supports to address challenging behavior results in better life outcomes for the child and youth. Research describes that children that engage in challenging behavior at early ages often end up on a life trajectory towards incarceration and school dropout. Providing early intervention services is of benefit to families and society.[15] [16]

Equity and Inclusion:
The stakeholder work to re-envision the home and community-based system could potentially impact any person receiving long-term services and supports. According to data from the LTSS Demographic Dashboard, as of January 2021, there were 1125,735 Minnesotans receiving LTSS. Of people receiving services, 61% were white and 34% were Black, Indigenous and People of Color. Minnesota's overall population was 79.1% white in the same timeframe. Therefore, improving the process for accessing LTSS will have a positive impact on communities of color and American Indian and Indigenous people. The Advisory committee will include a specific emphasis on diversity, equity, and inclusion in the system re-design to ensure that new service models that promote culturally responsive services leverage the strength of the Minnesota's diverse provider community, and that models meet the needs of people that identify as Black, Indigenous, or a Person of Color.

A primary goal of the 1915i study in this proposal is to find ways to increase critical intervention service access to People of Color, Native Americans, people with disabilities, and other underrepresented groups. The potential new service(s) would be designed for children, youth, and families that are experiencing out-of-home placements, hospitalizations, and long-term corporate foster care placements. Increased service access would also help children and youth sent to another state for treatment due to lack of access to valid and reliable behavioral

[7] Fettig A and Barton E. Parent Implementation of Function-Based Intervention to Reduce Challenging Behavior: A Literature Review. Topics in Early Childhood Special Education. 2013.

[8] Hieneman M and Fefer S. Employing the Principles of Positive Behavior Support to Enhance Family Education and Intervention. Journal of Child and Family Studies. 2017.

[9] Webster-Stratton C, Reid M, and Hammond M. Treating Children with Early-Onset Conduct Problems: Intervention Outcomes for Parent, Child and Teacher Training. Journal of Clinical Child and Adolescent Psychology. 2004.

[10] Dowse L, Cumming T, Strandova I, et al. Young People with Complex Needs in the Criminal Justice System. Research Practice in Intellectual and Developmental Disabilities. 2014.

[11] Kincaid A. P. Youth with disabilities in Minnesota's juvenile delinquency courts. (Minn-LInK Brief No. 31). 2016. Available at http://cascw.umn.edu/portfolio_tags/minn-link/. Accessed on July 20, 2022.

[12] Fettig A and Barton E. Parent Implementation of Function-Based Intervention to Reduce Challenging Behavior: A Literature Review. Topics in Early Childhood Special Education. 2013.

[13] Smith E and Turnbull A. Linking Positive Behavior Support to Family Quality-of-Life Outcomes. Journal of Behavioral Interventions. 2005.

[14] Hieneman M and Fefer S. Employing the Principles of Positive Behavior Support to Enhance Family Education and Intervention. Journal of Child and Family Studies. 2017.

[15] Dowse L, Cumming T, Strandova I, et al. Young People with Complex Needs in the Criminal Justice System. Research Practice in Intellectual and Developmental Disabilities. 2014.

[16] Webster-Stratton C, Reid M, and Hammond M. Treating Children with Early-Onset Conduct Problems: Intervention Outcomes for Parent, Child and Teacher Training. Journal of Clinical Child and Adolescent Psychology. 2004.

intervention services in Minnesota. Counties have shared that many children and youth that engage in challenging behavior have been placed on waivers to access to the waiver intervention services included in this study. However, not all people meet the criteria to access waiver services and some people may not wish to be on a waiver or may not even know they exist.

Research has shown that children and youth with disabilities, from black, indigenous, and communities of color, who engage in challenging behavior are more likely to experience family separation and juvenile detention[6] and children and youth with disabilities who are black, indigenous or people of color are overrepresented in the juvenile justice system.[1, 10] Finding ways to prevent family separation and juvenile justice system intervention through 1915i interventions services could reduce disparities for these populations.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

The outreach portion of the requested funding will require the vendor to consult with Tribal Nations to get input on service components. Tribal Nations may be members of the regional advisory teams.

Impacts to Counties:
Counties will primarily be impacted by the new curriculum and training for case managers. This provision was advanced by disability advocates in the 2022 session. Counties routinely partner with DHS to improve case management services for people with disabilities. They are equally committed to improving services for people and families.

IT Costs
There are no systems costs in this proposal.

Results:
Administrative resources to study to develop recommendations to expand access to several waiver services, including: positive support, crisis respite, respite, and specialist services. This proposal is expected to result in a study that will provide DHS and the Minnesota Legislature with potential options for the expansion of services used to support people in crisis or near crisis situations. The roadmap will include administrative actions the Department may take and legislative actions the Minnesota Legislature will consider in a future session.

Administrative resources to develop and implement a curriculum and training plan to ensure all lead agency assessors and case managers have the knowledge and skills necessary to fulfill support planning and coordination responsibilities for people who use home and community-based services. This proposal is expected to result in a training curriculum for all lead agency assessors and case managers, which in turn will result in more consistent training for all these workers and a consistent understanding of their roles, responsibilities and tools at their disposal.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			835	1064	1899	208	208	416
HCAF								
Federal TANF								
Other Fund								
Total All Funds			835	1064	1899	208	208	416
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	14	Admin FTE Study	125	375	500	0	0	0
GF	14	Admin FTE MAPE 17 (1, 1, 0, 0) Study	141	165	306			0
GF	REV1	Admin FFP @ 32% (study)	(85)	(173)	(258)	0	0	0
GF	REV1	Case management training grant	377	377	754	0	0	0
GF	REV1	Admin Case Management Training FTE (3, 3, 2, 2)	407	471	878	306	306	612
GF	REV1	Admin FFP @ 32% CM Training	(130)	(151)	(281)	(98)	(98)	(196)
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	14	ADSA Admin	4	4	4	3	3	3

Statutory Change(s):

Session law.

Change Item Title: Supporting Transitions for Small Customized Living Providers

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	909	1,828	1,018	1,018
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	909	1,828	1,018	1,018
FTEs	**2.5**	**2.5**	**1**	**1**

Recommendation:

Effective July 1, 2023, the Governor recommends (1) establishing a grant for small Customized Living (CL) providers to comply with foster care or community residential setting licensing requirements and (2) allowing special payments to customized living service providers that receive approval from the Department of Health to close a licensed assisted living facility. The Governor recommends $2.7 million in the FY24-25 biennium and $2 million in the FY26-27 biennium.

Rationale/Background:

Since 2009, there has been a licensing moratorium on new corporate foster care development. In certain circumstances, a person may access services in this type of setting, and a provider may receive a new "bed" by receiving an exception to the moratorium, which are identified in statute. The 2021 Legislature, acting on Blue Ribbon Commission recommendations, created a moratorium on customized living services for people living in single family home settings with four or less people. The moratorium allowed settings licensed for four or fewer people to transition to the appropriate service, using a corporate foster care moratorium exception. Providers have expressed they may need to make physical plant upgrades to either transition to corporate foster care or assisted living licensures.

The implementation of the new assisted living license on August 1, 2021, as well as historic workforce challenges, have brought significant changes to the landscape of providing assisted living and waiver-funded customized living services to older adults and people with disabilities. Based on recent data from the Department of Health, between 75 and 160 licensed assisted living facilities close each year. These closures impact approximately 250 to 1,000 Medicaid waiver participants.

Special payments during the 60-day closure period would help providers continue to serve all residents as the facility's occupancy and revenues decline. These payments would also help ensure that the health and safety needs of Brain Injury, Community Access for Disability Inclusion, and Elderly Waiver participants are met during the closure period, until they can relocate to another residential setting. These special payments are especially critical to licensed assisted living facilities that serve a high proportion of Medicaid enrollees.

Proposal:

This proposal includes the following provisions to allow for BI/CADI customized living settings to transition to the most appropriate regulatory framework.

1. *Transition Grants for small, customized living BI/CADI settings*

This provision establishes a temporary grant related to the proposed Customized Living moratorium exceptions. Eligible uses of grant funds include expenses for providers transitioning to community residential services licensure or to Integrated community supports. Funds may also be used for provider technical assistance focused on ensuring BIPOC providers have the tools to maintain and expand access to culturally-responsive services. To be considered for grant funding, license holders serving people with approved exceptions must submit a grant application to the commissioner by June 30, 2024. The commissioner may approve and fund grant applications on a rolling basis. Grant funds can be used for licensing requirements outlined in Minnesota Rule 9555.6205 and/or Minn. Stat. 245D.24.

Staff for DHS. This proposal includes 2 temporary FTEs at DHS to administer the additional grants, manage contracts, ensure fiscal oversight, and provide technical assistance to grantees, as well as provide process financial payments, review contracts, and perform other administrative functions.

2. *Assisted Living Facility Closure Payments*

This proposal creates a new special payment program for customized living services providers that are approved by the Department of Health to close a licensed assisted living facility. To be eligible for special payments, a provider would need to have an approved closure plan with the Department of Health, and an approved payment plan with the Department of Human Services. Facilities that are discontinuing an assisted living license to pursue a different license type, or going through a change in ownership, would not be eligible.

The special payments would be issued to providers as 50% add-ons to customized living claims submitted by the facility during the 60-day closure period. The claims add-on would be paid by DHS and Managed Care Organizations through their payment systems. Federal approval would be needed to issue these special payments, and to ensure Minnesota receives federal match for the payments.

Staff for DHS. This proposal includes 1 FTE at DHS to perform administrative functions of processing approved payment plans for eligible providers, including coordination with MDH and DHS licensing to ensure all eligibility requirements are met.

Impact on Children and Families:

This proposal does not affect children since children do not receive customized living services. This proposal would indirectly benefit families who are supporting older adults and people with disabilities going through an assisted living facility closure.

Equity and Inclusion:

Supporting Small Customize Living Providers

This proposal affects people with disabilities who receive, and providers that render, customized living services available through the CADI and BI waiver programs. Most settings that serve eligible people are in Hennepin County. In Hennepin County in calendar year 2020, customized living was the:

- 1st most frequently used service by people who identified as Native American;
- 3rd most frequently used service by people who identified as African American/Black, Hispanic, two or more races, and white; and
- 4th most frequently used service by people who identified as Asian or Pacific Islander.

This proposal will provide an option for people and providers to switch between customized living services and community residential services. This change would also require providers to obtain a 245D HCBS license (if the provider did not already hold one) and a community residential setting license.

A potential negative impact as a result of this proposal could be the extent to which a change in service in license types is driven by the provider, as opposed to the needs of people receiving services in a particular setting. This proposal requires case managers to provide people with an informed choice of their services related to this change, but a provider's decision about pursuing this change could create housing and service instability for a person, should their preferences diverge from the provider supporting them.

Assisted Living Facility Closure Payments
The assisted living facility closure payments will benefit people who are black, indigenous or people of color because a growing number of waiver participants are from these communities. Between 2016 and 2020, the number of black, indigenous and people of color on Elderly Waiver (and Alternative Care) grew from 26 to 32 percent. During the same time period, the number of black, indigenous and people of color on Brain Injury Waiver and Community Access for Disability Inclusion Waiver (and the Community Alternative Care Waiver) grew from 24 to 30 percent.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:

Assisted Living Facility Closure Payments
The assisted living facility closure payments will benefit counties, because they will help ensure that the health and safety needs of Brain Injury, Community Access for Disability Inclusion, and Elderly Waiver participants are met during the closure period, until the counties can relocate the participants to another residential setting. The payments may also allow the waiver program participants to stay longer in the facility, which will allow more time for counties to support a participant's transition.

IT Costs

Supporting Small Customize Living Providers
There is no IT impact related to this proposal.

Assisted Living Facility Closure Payments
This proposal requires MMIS system changes to issue the special facility closure payments to eligible and approved facilities.

Results:

Supporting Small Customize Living Providers
DHS currently monitors the number of beds and settings that access all corporate foster care moratorium exceptions. In the first 2 months of the existing customized living moratorium exception being implemented, 3 settings have accessed the moratorium exception. This follows extensive DHS communications to eligible providers and affected counties prior to implementation of the exception. This indicates that, despite stakeholder pressure, there is not great demand for small customized living settings to transition via moratorium exceptions to corporate foster care.

If this proposal became law, DHS would continue monitoring use of moratorium exceptions.

Assisted Living Facility Closure Payments
Special payments to assisted living facilities going through a closure will help ensure the health and safety needs of people in the facility receiving customized living services under the Brain Injury, Community Access for Disability Inclusion, and Elderly Waiver programs.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-215	FY 26	FY 27	FY 26-27
General Fund			909	1,828	2,749	1,018	1,018	2,036
HCAF								
Other Fund								
Total All Funds			909	1,828	2,749	1,018	1,018	2,035
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	55	Disabilities Grant (Small CL Closure Grants)	650	650	1,300	0	0	0
GF	14	Admin DSD	265	306	571	153	153	306
GF	11	11 Admin Central Ops	71	82	153	0	0	0
GF	REV1	Admin FFP @ 32%	(107)	(124)	(232)	(49)	(49)	(98)
GF	11	33-CL Rate Enhance MC	0	681	681	681	681	1,361
GF	33	33-CL Rate Enhancement FFS	0	227	227	227	227	454
GF	11	11 MMIS Systems Costs	30	6	36	6	6	12
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	14	Admin ADSA	2	2	2	1	1	1
GF	11	Admin Central Ops	0.5	0.5	0.5	0	0	0

Statutory Change(s):

Minn.Stat. §245A.03, 245A.11, 256S.203, 246S.206, session law

Change Item Title: Capacity and workforce expansion programs

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	6,096	26,192	26,192	26,192
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	6,096	26,192	26,192	26,192
FTEs	**8**	**11**	**11**	**11**

Recommendation:

The Governor recommends investing $32.3 million in fiscal years 2024-2025 and $52.4 million in fiscal years 2026-2027 from the general fund to address Minnesota's long term care workforce shortage and expand the home and community-based provider industry. This investment includes two permanent grant programs geared towards strengthening the service capacity of the long-term care (LTC) workforce:

1. Grants to providers to strengthen the service capacity of long term care and home and community-based providers throughout Minnesota.
2. Grants to support New Americans in the LTC Workforce. Grant money will provide training, connection, and other supports to those interested in joining the long-term care workforce. Grant dollars would additionally connect LTC employers with a trained, skilled, and culturally diverse workforce.

In addition, this proposal includes two additional strategies to further strengthen the long term care sector and support reform to increase access across the state. This proposal will have a significant impact to service providers serving people with disabilities and older adults due to the number of LTC positions vacancies statewide, the current workforce shortage, and the predicted increase in need for the long-term care workforce. This proposal increases Aging and Disability Services Administration (ADSA) administrative spending by 3.6% and increases ADSA Grant spending by 20.8% as compared to FY2021.

Rationale/Background:

The past few years of COVID-19 paired with an increasingly aging demographic with complex needs and increasingly limited workforce have caused many LTC providers to close their doors. This is particularly true in rural and BIPOC communities, with many long term care providers struggling to remain in business. Service providers need additional support to serve our changing and aging population while also providing quality care.

COVID-19, the workforce shortage and increasing healthcare needs have disproportionately affected small, community-based provider organizations, particularly those in Greater Minnesota and communities of color. The Provider Capacity for Rural and Underserved Communities grants program aims to address this gap by offering grant dollars to providers serving within these communities. This grant program is currently temporarily funded through one-time funding, but thus far has provided critical support to new and smaller organizations serving the most underserved areas and communities of the state.

Additionally, this proposal seeks funding to address the long-term care and direct service professional (DSP) workforce shortage by creating a new grant program for organizations that support, train, and recruit immigrants, refugees, and New Americans into these positions. The shortage of LTC and DSP workers has worsened due to the

COVID-19 pandemic, low pay, and worker burnout. This deficit will continue to grow as shifting demographics and an aging population increase the need for these services. Many immigrants and refugees have the existing skill set to participate in the long-term care workforce. Many more are interested but don't have the knowledge or community resources to move forward.

Proposal:

This proposal provides permanent funding to strengthen the long term care sector through grants and other supports. This proposal has four parts:

1. Continuing the Provider Capacity for Rural and Underserved Communities grant program by making it permanent,
2. Establishing a new grant program focused on recruiting and retaining immigrants, refugees and New Americans in the LTC workforce.
3. Extending the existing Age-Friendly Minnesota Council through June 30, 2027 to complete the work of Minnesota's commitment into the Age-friendly Network of States and Communities.
4. Conducting an actuarial research study of public and private financing options for long-term services and supports reform to increase access across the state.

These programs will provide resources towards enhancing long-term care service capacity while increasing access and equity to services, thereby expanding and enhancing quality of LTC and the LTC workforce.

Provider Capacity for Rural and Underserved Communities

The first strategy provides permanent funding to a temporarily funded grant program that directly supports HCBS providers in rural and underserved communities. The program provides grant dollars to assist entities in becoming an HCBS provider, expand to a new HCBS service, or increase access to HCBS in rural and underserved areas. In addition to increasing the number of HCBS providers serving rural and underserved communities, the goal of the program is to increase the number and capacity of culturally specific providers, so that people who receive services will have the opportunity to receive services from providers who are a part of their community and may have shared histories, languages, cultures and norms. Grants can cover the costs emerging providers incur when becoming an HCBS provider, such as licensing and enrollment fees, staff time to become an enrolled provider, and establishing operational needs.

The program is unique as it focuses on reaching small and newer providers, many that have not applied for DHS funding opportunities before. To reach the organizations intended for the grant, the application process has been simplified and streamlined with an application that is accessible for applicants where English is not a primary language or that are new to the state procurement process. Grant administrators provide additional levels of assistance to support grantees through the process.

For existing HCBS providers, grants can pay for the costs associated with starting a new service or expanding to new geographic area. Grants can also enhance an organization's capacity to increase services such as language supports, staff training, and culturally responsive practices. Grants are dedicated to organizations serving rural and underserved communities – areas we know are increasingly impacted by the workforce shortage and lack of providers.

To enhance grantees' success, a community of practice and ongoing technical assistance effort also supports grantees. DHS will continue to promote this community of practice, which serves as a venue for providers to collaborate and learn from each other. Technical assistance is available to grantees to support accessing Medicaid reimbursement as well as existing DHS state and federal grant programs.

Future grant opportunities will be available to further enhance service capacity and for organizations not already in the program. Permanently funding this program will increase the number of small, community-based and

culturally specific providers, serving in the most underserved areas of the state. Permanently funding the program will also strengthen the viability of these organizations to provide these services in the long-term.

New Americans in LTC Workforce

The second strategy of this proposal includes a grant program which aims to support the LTC workforce by providing grants to community-based organizations with proven skills in serving this population (immigrants, refugees and people born outside of the United States). The goal of the LTC workforce program is to identify, recruit and retain new workers to the long-term care workforce. Recipients of the grant dollars will work to identify potential people interested in becoming long-term care support professionals and in turn connect them with hiring organizations.

Granted organizations will serve as a one-stop shop for immigrants, refugees and New Americans interested in entering the LTC workforce. They will provide connections to employment, career counseling, mentoring, and the comprehensive support necessary to maintain employment. Also of critical importance, grantee organizations will offer comprehensive services to employers, matching them with skilled employees and providing training and education on cultural competency.

Grantee organizations will also be culturally competent and well-versed in the challenges faced by new workers, acting as a liaison between them and LTC providers. Funded organization will also provide support to workers needed to maintain employment. Such supports include, but are not limited to, help with transportation, housing, childcare, language needs, and access to the existing LTC community, all of which are critical for workforce retention.

Selected grantee organizations will support immigrants, refugees, New Americans, and the LTC employers with the following functions:

Career Matching: Grantee organizations will develop programs to match prospective employees with local long-term care employers. Grantee organizations will establish partnerships with employers in the long-term care field and learn their unique needs and skills. Trainings and skill matching will be rooted in the needs of the employers throughout the partnership. Participants will be matched with employers based on skills and interest.

Career Counseling: Grantee organizations will provide career counseling to workforce participants and employers. Grantee organizations will provide support to prepare workforce participants for employment, including purchasing uniforms or other professional attire, support with paperwork and interviews. Also critical, grantee organizations would prepare employers for these new workers as well. Actions could include cultural competency training, information on employees' culture and beliefs, and suggested communication methods.

Training: Grantee organizations will provide training and skills developments to participants and employers. Workforce trainings will include trainings for licensure requirements, language development and guides to working in the LTC field. Specifically, training will provide a Know Your Rights course to all participants in acknowledgement that work styles and expectations may be different based on previous foreign experience. In addition, grantee organizations would provide skills development to promote career advancement. Employers must receive cultural competency training to ensure workers feel respected, welcome, and safe throughout their employment.

Mentorships: Employee retention is more likely to succeed if employees develop relationships with fellow employees. Grantee organizations would match prospective employees with peer mentors. Mentors can receive reimbursement for their participation and would be matched to new employers in accordance with background and employment interest.

Community integration: Grantee organization, in conjunction with participating employers, will support participants in adjusting to both the community and employer. Programs might include:

- Navigation transportation options
- Identifying culturally specific grocery and food options
- Locating relevant religious and community centers

Employment supports: Grant funds will be available for supports that will help participants begin and maintain employment. These supports could include stipends for childcare, transportation assistance and housing. Additional supports would be available to for the families of participants as well, such as tutoring and after school programs and mental health services and supports. Support on navigating the school system and supporting school-age children will also be available.

Language: Many careers in the long-term care field require some level of English proficiency. Grant funds will be available for participants to access English language classes, including classes in reading and written language skills, and support for interpretation services. Additionally grants funds are available for employers to develop translated training materials in multiple languages.

Legal services: Legal services for the New American participants is essential. Grant funds will be available for grantees to employ or consult outwardly for legal services for LTC workforce participants. Services could include citizenship application assistance, asylum case management, immigration documentation assistance, and connection to citizenship courses.

Financial coaching: Grantees will connect employees with financial coaches to support participants with financial literacy, taxes and establishing checking, savings and other financial accounts.

Benefits education: Benefits coaches support participants with benefits and government assistance programs eligibility. This includes support on navigating the health care and health insurance system.

Case management services: Funds would be available for mental and physical health services and supports, including case management services if needed.

DHS's overarching goal is to ensure that the solicitation of these grants is comprehensive and recognizes the diversity of organizations. As such, the GEAR Division staff will consult with fellow administrations including the Office of Refugee Services, Office of Economic Opportunity, Child and Family Services and the Healthcare Administrations on the RFP development to ensure that the solicitation is comprehensive and that grant award process to ensure that grantee selection recognizes the diversity of organizations that serve immigrants and those new to the United States.

Extension of the Age-Friendly Council and Community Grants

As Minnesota surpasses one million older adults this year, the third strategy of this proposal extends the newly established Age-Friendly Council through June 30, 2027 to complete the work of Minnesota's entry into the World Health Organization's Age-friendly Network of States and Communities[1]. This proposal seeks to also extend the essential funding for small community and technical assistance grants to 100 counties, tribal nations, and/or community organizations seeking to become Age-Friendly Communities.

In 2022, Minnesota became the 10th State to join the AARP network of Age-Friendly States and Communities. The Age-Friendly Council is working to establish a strong partnership with age-friendly health systems, university and public health and non-aging partners including law enforcement, economists and public and private

[1] In 2019, Governor Walz signed EO 19-38 to create an Age-Friendly Council and enter the national network of Age-Friendly States. In the 2021 Special Session, the Legislature showed bipartisan support for the establishment of the Council and established funding through March 31, 2024.

foundations. This three year extension allows for the Council to complete its initial obligations of being an Age-Friendly State.

Research to Increase Access to Long Term Care Services

A fourth strategy includes an actuarial research study of financing reform options for LTSS to increase access to Home and Community-Based Services, specifically looking at innovative ways at financing LTSS through collaboration of both the private and public sectors.

Minnesota, like much of the rest of the US, is becoming older and the programs and policies that have been in place for decades to help older Minnesotans are not going to be sustainable in the long term. For example:

- Between 2010 and 2050, the number of Minnesota older adults will grow by 30 percent
- Older adults over age 65 have a 70% risk of needing long-term care at some point in their lives
- Overwhelmingly, older Minnesotans do not want to receive that care in an institution

The main objective is to provide a policy structure which can help transform the LTC funding system in Minnesota by helping integrate several of the existing public and private programs that provide LTSS financing to Minnesota's older adults. This initiative is intended to offer a sustainable age-friendly approach for individuals, families, caregivers, private sector insurance, and government programs to address the current and future needs of older adults in Minnesota.

Impact on Children and Families:

This proposal impacts children and families as the long-term care workforce is predominately women with children and families of their own. This is even more true for the LTC workforce not born in the United States. Strengthening this part of the workforce through career connection, job coaching, and job supports will lead to finding and retaining employment. The steady employment and maintained wages of caregivers directly benefits children. For the New American in LTC workforce program, the supports available through the grant funds, such as navigation of childcare and the school system, the health insurance and healthcare benefits system and community integration will directly impact children and families as well. Additionally, program will directly support children by funding tutoring services, after school programs, and mental health supports.

The children and families of people receiving long-term care supports will also benefit from both of the programs this proposal. The funding in this proposal intended to increase the LTC workforce, the number and availability of long-term care services and more directly to increase the number of culturally specific LTC professionals and organizations. Families will benefit from having a more robust workforce that reflects the changing demographics of Minnesota.

Equity and Inclusion:

This proposal has a direct impact on equity, particularly economic and health equity. Grant funds will directly support immigrants, refugees and New Americans to enter the LTC workforce and maintain employment; many that have been systematically oppressed, are women and people of color. This program not only connects participants to employment, but it will also reduce barriers to employment, supporting maintaining employment and community integration while providing employment and economic advancement opportunities.

The proposal also encourages the economic vitality of culturally specific providers and organizations serving underserved areas of the state. Likewise increasing the number and capacity of providers serving underserved areas also directly increases access to services in those areas.

Additionally, this proposal has the unequivocal benefit of increasing the diversity of the long-term care workforce. As Minnesota's demographics shift and the aging population is becoming increasingly diverse, the value of having a well-skilled and culturally competent workforce that reflects the population they serve cannot be overstated.

This proposal will positively impact immigrants, refugees and those new to the United States, through economic opportunity, maintained employment, career ladders, and integration to community.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☐No

The LTC workforce shortage disproportionately impacts Tribes. Providing more skilled workers in the LTC workforce will be a benefit to Tribes.

An FTE is requested to work with counties and Tribes on addressing workforce capacity. However, this proposal will not impact tribes financially or administratively. Tribes will not need to hire additional staff nor be responsible for administering the grant program.

Impacts to Counties:

As noted above, an FTE is requested to work with counties and tribes on addressing workforce capacity. However, this proposal will not impact counties financially or administratively. Counties will not need to hire additional staff nor be responsible for administering the grant program.

IT Costs:

There are not any systems related costs associated with implementation of the proposal.

Results:

Provider capacity will increase as more skilled workers will enter the LTC workforce. Retention rates in LTC settings will also increase. The diversity of the LTC workforce will expand to reflect the increase of immigrants, refugees and New Americans serving in these settings.

Type of Measure	***Name of Measure***	***Dates***	***Measure***
Quantity	The number of immigrants, refugees, and New Americans receiving employment supports and entering the LTC workforce.		Number of LTC workers and DSPs will increase.
Quality	More workers will enter the LTC workforce with the necessary support to maintain employment and provide quality care to those requiring services.		This measure support quality of care and employment retention.
Results	More workers will be in the LTC workforce resulting in a decreasing in the shortage.		

Fiscal Detail:

The cost of this proposal includes the costs for implementing a new grant program focused on supporting New Americans and increasing the diversity in the LTC workforce.
The costs include:

- One (1) unit director (15M)
- One (1) unit supervisor (21K)
- One (1) program coordinator and policy specialist (17L)

- Three (3) grants administrators (14L)
- One (1) fiscal compliance specialist and data specialist (14L)
- One (1) engagement and evaluation specialist (14L)
- Funding for up to $5 million in grant funds the first year and $15 million in grants each subsequent fiscal year.
- Ongoing funding for provider capacity at $8 million per fiscal year starting in fiscal year 2025
- Funding for community engagement and technical assistance efforts; approximately $250,000 each year.
- Funding also includes three (3) temporary positions for the grant extensions

Net Impact by Fund (dollars in thousands)			**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
General Fund			6,096	26,192	32,288	26,192	26,192	52,384
HCAF								
Federal TANF								
Other Fund								
Total All Funds			6,096	26,192	32,288	26,192	26,192	52,384
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	52	Other LTC Grants	5,000	23,000	28,000	23,000	23,000	46,000
GF	14	Admin (FTE 8, 8, 8, 8)	537	1,276	1,813	1,276	1,276	2,552
GF	14	Admin P/T Contracts Technical Assistance and Community Engagement	375	375	750	375	375	750
GF	REV1	Admin FFP @32%	(292)	(528)	(820)	(528)	(528)	(1,057)
GF	53	Aging and Adult Services Grants	0	1,575	1,575	1,575	1,575	3,150
GF	14	ADSA Admin (FTE 3,3,3,3)	0	476	476	476	476	951
GF	14	Contract for DEI	0	250	250	250	250	500
GF	REV1	Admin FFP @ 32%	0	(232)	(232)	(232)	(232)	(464)
GF	14	Admin P/T Contract for LTC actuarial study	700	0	700			0
GF	REV1	Admin FFP @32%	(224)	0	(224)			0
					0			0
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	14	Admin (FTE 8, 11, 11, 11)	8	11		11	11	

Statutory Change:

Inserts new permanent grant programs into chapter 256

Change Page Title: Vulnerable Adult Act Redesign – Phase 2

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	12,046	13,053	14,269	14,376
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	12,046	13,053	14,269	14,376
FTEs	**4**	**6**	**10**	**10**

Recommendation:

The Governor recommends investing $25.1 million in FY 2024-2025 and $28.6 million in FY 2026-2027 to address disparities in adult protection services of people with disabilities and older adults residing in their own homes through funding to counties and tribes to improve statewide equity and outcomes for those experiencing suspected maltreatment.

This proposal provides foundational funding to Tribal Nations to establish and provide protection services for tribal members in need of services to stop, prevent, or reduce the risk of maltreatment. This proposal supports the Commissioner's responsibility to supervise the county administered adult protection system (APS) through training, consultation and policy guidance. It will also allow DHS the ability to evaluate responses to APS referrals and use performance measures to ensure equity in service outcomes for all adults referred for alleged maltreatment.

This proposal also invests $1.9 million per biennium to provide a more reliable technology platform for the Minnesota Adult Abuse Reporting Center (MAARC) in order to reduce unplanned outages that interrupt workflow, which increase costs to MAARC and to counties, DHS and MDH. This proposal will ensure federal compliance with required reporting by DHS to the Centers for Medicare and Medicaid Services (CMS) for adults receiving Medical Assistance waiver programs and assist the DHS Commissioner with their responsibility to effectively monitor critical steps in responses to MAARC referrals.

This proposal is necessary to allow the public access to web-based reporting options and minimize the need for additional MAARC operational costs and enhance the technology in order to evaluate demographic information to ensure equity in outcomes for all vulnerable adults in Minnesota, regardless of where they reside.

Rationale/Background:

Adult Protective Services Grants to Counties

Invest $36 million over FY 2024-2027

Minnesota's Adult Protective Services (APS) acceptance rate is significantly lower than the national average of 58.3% captured in the federal National Adult Maltreatment Reporting System (NAMRS) report in 2021. Currently, counties in Minnesota administer adult protection programs to stop, prevent, and reduce risk of maltreatment reoccurrence for vulnerable adults referred by the Minnesota Adult Abuse Reporting Center (MAARC). However, only 39% of those meeting criteria for maltreatment under the Vulnerable Adult Act (VAA) are accepted by counties for APS. Those not accepted by counties are disproportionately screened out based on the county

responsible, race, age, and type of disability. More specifically, protection for and assistance to vulnerable adults experiencing maltreatment is highly dependent on the funding of local counties, as the state funds approximately 50% of APS costs and no federal funds are available for these services.

This lack of state funding results in a significant difference in the number of adults receiving protective services across counties and is inconsistent with the intention of the Vulnerable Adult Act legislation. Fiscal data shows statewide county expenditures for adult protection increased from $9.7 million in 2017 to $12.7 million in 2021 and counties were responsible for responding to approximately 30,000 vulnerable adults referred to counties by MAARC in 2021 for adult protective services due to suspected maltreatment. However, while approximately 18,000 of those adults met the state policy criteria for APS, only approximately 7,000 vulnerable adults were accepted by Minnesota counties for protective services to safeguard them from maltreatment. As a result, approximately 11,000 adults who met criteria under the VAA were screened-out for APS through the counties' administrative ability to prioritize who will be serviced under MN Statute 626.557.

In 2019, DHS initiated the Vulnerable Adult Act Redesign Project in response to feedback from the community and other adult protection stakeholders. The project found the state's APS system to be underfunded, which creates disparities in the service response to vulnerable adults depending on the county of residence. There was clear consensus across all stakeholders that without dedicated state funding for APS services, the inequities and inconsistencies in response and service delivery will continue.

Adult Protective Services Grants to Tribal Nations

Invest up to 4.4 million over FY 2024-2027

Currently, Tribal Nations do not receive state or federal funding to provide culturally appropriate adult protective services for their vulnerable adult members. Tribal Nations also do not receive referrals from the Minnesota Adult Abuse Reporting Center for which state grant allocations depend, creating inequity between county agencies and tribal human services. Funding will allow Tribal Nations with resolutions establishing vulnerable adult protection programs the ability to administer culturally appropriate APS programs to vulnerable adult members of their communities.

Enhance the Social Service Information System (SSIS) to improve equity analysis

Invest $1.2 million over FY 2024-2027

A review of the data collected in Social Service Information System (SSIS) identified gaps in data elements that are essential to performing adequate equity analysis to understand disparities in service and minimize impacts to vulnerable adults. Current data is inconsistent, absent or limited in descriptive information for the individual. Comprehensive information on the person is essential in identifying disparities, directing efforts and resources for remediation, and measuring progress in achieving equitable outcomes. The lack of adequate data limits the ability to identify and address disparities in service, as inequities will remain unseen and unaddressed.

MAARC Operations

Invest $153,623 over FY 2024-2027

In 2012, the reporting of suspected abuse, neglect or financial exploitation of vulnerable adults moved from a county-based system to state centralized reporting to the Minnesota Adult Abuse Reporting Center (MAARC) under Reform 2020. MAARC operations include a call center for the public and a web-based reporting system for mandated reporters. MAARC accepts reports and makes timely required referrals for all Adult Protective Service (APS) reports to law enforcement, the medical examiner, counties, and to the lead investigative agencies responsible for a response. Lead investigative agencies include DHS-Office of the Inspector General (OIG) and MDH-Health Regulation Division (HRD) when a licensed provider is alleged responsible. Counties in Minnesota are responsible for APS as lead investigative agencies when the person alleged responsible is a Personal Care Assistant (PCA), the person is not associated with a licensed program, or when the vulnerable adult is unable to meet their own needs to ensure their own health, safety or comfort.

In 2022, MAARC accepted and made timely required referrals for over 59,000 reports of suspected maltreatment of a vulnerable adult and made over 6.500 non-maltreatment referrals for callers. The Reform 2020 funding for MAARC operations has not been increased to meet operational costs for the reporting center and the center's workforce since 2012. This proposal requests a 3% annual increase to the MAARC operations budget to support established service levels for the public and mandated reporters, and to ensure compliance with timely referral to agencies responsible for responding to vulnerable adults. The budget is used to purchase professional technical vendor services that increase in costs yearly and are not included in the agency's operational adjustment.

MAARC Re-Platforming

Invest $5.4 million over FY 2024-2027

The Minnesota Adult Abuse Reporting Center (MAARC) is required to be available to mandated reporters and the public 24/7/365. This means DHS must sufficiently staff the Call Center to meet its obligation to callers during evenings, weekends and holidays, which increases expenses and workforce challenges. Web reporting is less resource intensive for the agency. Each phone report costs the agency $42.52 whereas each web-based report costs the agency $3.56. Approximately 55% of reports to MAARC were made through a web-based system available to mandated reporters. Approximately 50% of the calls made to MAARC in 2021 were from mandated reports who choose not to use the web reporting system and the remainder of the calls to MAARC were from the public.

In addition, MAARC experienced 35 high impact and 117 systems issues between 2019 and 2021 which impacted service levels for those making reports, interrupted business workflows, and increased the operational cost. Following a detailed analysis, MNIT recommends that the MAARC be re-platformed into a new application.

An improved web-based reporting system that is intuitive and user friendly will expand usage, minimize technical support, and reduce operating costs. This effort will also increase public trust in a state reporting system through improved reliability and accessibility.

Vulnerable Adult Data Mart Maintenance and Operations

Invest $2.0 million over FY 2024-2027

The vulnerable adult data mart meets DHS's responsibility for required reporting to the Centers for Medicare and Medicaid Services (CMS) on the health and safety of adults participating in Medical Assistance wavier programs, who have experienced alleged maltreatment. It also provides data for outcome evaluation for the Human Service Performance Management System and data required under the Vulnerable Adult Act (VAA) to meet the DHS Commissioner's responsibility to track critical steps in outcomes for adults reported to the Minnesota Adult Abuse Reporting Center (MAARC). New versions of the Social Services Information System (SSIS), the data system used to manage maltreatment reports, investigation, service response and remediation, are released quarterly. It's necessary to maintain the data mart for reports and analysis to be accurate, valid and reliable.

Proposal:

1. ***Obtain funding necessary to improve statewide consistency and equitable outcomes for vulnerable adults reported to MAARC for abuse, neglect, or exploitation.***

In 2021, county agencies were responsible for Adult Protective Services (APS) response for over 31,000 vulnerable adults who were the subject of MAARC reports. DHS estimates county agencies expended $12.7 million for APS in that calendar year while state grants allocated $5.6 million for APS. Inadequate funding by the state for the needs of adults referred to APS results in inconsistent and inequitable responses by the counties. As a result, service response for vulnerable adults depends on their county of residence and varies from 0-88% across the state.

This proposal supports consistent and equitable Adult Protective Services (APS) response and outcomes for all vulnerable adults, regardless of where they live in the state. Current state allocations are insufficient, and some counties receive less than $5,000 annually. This proposal appropriates new state grant funds to support adult

protection investigation and service response to stop, prevent and reduce risks for adults who are vulnerable and maltreated totaling more than $36 million across two biennium. A minimum allocation will be made for each county sufficient to establish a base level for adult protective services programs. This will increase access to equitable services statewide for vulnerable adults meeting policy criteria for APS.

2. Support Minnesota Tribes in the development and enhancement of Adult Protective Services to their tribal members.

This proposal will provide resources for Tribal Nations to develop and provide Adult Protective Services to their tribal members by allocating up to $1.1 million annually across tribal nations with resolutions establishing a vulnerable adult protection program.

3. Obtain funding necessary to improve equity analysis within SSIS

This proposal will provide funding needed to enhance SSIS by adding additional demographic fields needed to improve equity analysis of vulnerable adults referred for and accepted for APS.

4. Obtain funding necessary to increase funding for MAARC Operations by 3%

This proposal will provide funding for a 3% annual increase to the MAARC operations budget to support meeting service levels established for the public and mandated reporters and for compliance with timely referral to agencies designated to respond to vulnerable adults.

5. Obtain funding necessary to re-platform MAARC

This proposal will provide funding to replace SSIS-VA with a new or upgraded web portal in a phased approach. The web portal would become the primary system for the Call Center users. The first phase aims to increase web portal usage, and add features that reduce procedural dependencies on SSIS-VA. The second phase adds bi-directional integration to eliminate the technical dependencies on SSIS-VA.

6. Obtain funding for on-going maintenance and operations of the vulnerable adult data mart

This proposal will provide funding to keep updated versions of the vulnerable adult data mart needed for the Commissioner's duty to track critical steps in APS from report to appeal. In addition to the required data reporting to CMS and Human Service Performance Management.

Impact on Children and Families:

This proposal does not have a direct impact on children. However, from a whole family, inter-generational perspective, Minnesota children, youth, and families experience indirect benefits from investments in ensuring an adequate statewide response to reports of maltreatment to vulnerable adult family members across the entire state.

Equity and Inclusion:

In 2021, DHS completed an evaluation of service outcomes for adults referred to the county administered APS system. The evaluation identified geographic, racial and disability-based inequity in APS service response for adults referred through MAARC, as under MN 626.557 counties are allowed to "screen out" referrals to prioritize services.

That year, approximately 31,800 reports of suspected maltreatment of adults were referred to county APS. However, the counties only accepted 20% (6,510) of the referrals and offered services to adults to intervene and prevent further maltreatment even though 56% (17,814) adults met state policy criteria for APS.

The evaluation reflected that screen out rates varied considerably by county (ranging from 0-88%), indicating that a vulnerable adult's county of residence is a significant factor in determining access to services. The evaluation identified statistically significant inequities in screen-out rates. Racial and ethnic minorities are statistically more likely to be screened-out for adult protective services than Caucasians.

Screen-In rate by race:

- Caucasian 50%
- American Indian/Alaskan native 39%
- Asian 32%
- Pacific Islander 30%
- Black or African American 20%

In addition, the evaluation also indicated variance among access by the vulnerable adult's disability type, with particularly high screen out rates for persons with chemical dependency, mental health, and brain injury. Additional insight has been gained, that counties are not accepting reports of suspected maltreatment of vulnerable adults meeting policy criteria for services when they are in the hospital or receiving other service system supports.

Increased resources to counties and Tribal Nations providing adult protection services are expected to result in service outcomes to stop, prevent, and reduce the risk of maltreatment reoccurrence for vulnerable adults meeting the criteria for APS and improve equity by race and disability. Also, Tribal Nations are not currently receiving state grant allocation for APS, as none currently provide these services under section 626.557. This proposal, if passed, would bring equity and resources to tribes to develop, operationalize, and enhance APS to their members.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Tribal Nations are currently not receiving state grant allocation for APS, as none currently provide these services under section MN 626.557. This proposal will allocate the first ever-state grant funding to Tribal Nations to develop and provide APS to their tribal members. Multiple tribal leaders stated access to culturally appropriate adult protective services is a priority need during the DHS-Tribal 2023 Legislative Summit conducted on September 8, 2022. It would also bring equity and resources to Tribal Nations so they can develop, operationalize, and provide APS to vulnerable adults within their communities.

Impacts to Counties:

This proposal has a large statewide impact on counties. This proposal works to lessen the fiscal inequity gap created by limited county tax bases that currently fund Adult Protective Services. With additional resources counties will be able to serve more vulnerable adults suspected to have been abused, neglected, or exploited who meet the policy criteria for APS but are currently not being accepted. It will also improve equity compared to those who are accepted.

Results:

More adults referred by the Minnesota Adult Abuse Reporting Center (MAARC), who are vulnerable and suspected of experiencing abuse, neglect or financial exploitation, will be safe from maltreatment, as they are accepted by counties for Adult Protective Services to stop, prevent, reduce risk and remediate maltreatment. DHS expects a 25% increase over four years in the number of adults being accepted by counties for protective services.

The DHS Commissioner will have resources to support counties and Tribal Nations with adult protection program administration through training, systems, policy support, data collection, analysis, grant management and performance evaluation.

The Commissioner will establish equity measures and service outcome performance standards for adults referred to APS. Measures and standards will be established in partnership with the Minnesota Association of County Social Service Administrators (MACSSA).

Members of Tribal Nations will be safe from maltreatment, as the Tribal Nations will have resources to serve vulnerable adults within their communities to stop, prevent, reduce risk and remediate maltreatment consistent with their culture and tribal code. MAARC will have technology to stabilize operations and a web-based reporting option for the public to support 24/7/365 reporting providing DHS a long-term strategy for cost containment for the agency's responsibility to accept and make timely required referrals for reports of suspected vulnerable adult maltreatment.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity				
Quality	Human Service Performance Management System – Initial disposition. Threshold 90% percent of vulnerable adults reported as maltreated with initial disposition for response made within five working days		CY21 90.56%	This measure supports timely response for vulnerable adults that may be experiencing maltreatment
Results	Human Service Performance Management System – Repeat substantiated maltreatment of a vulnerable adult. Threshold 80%, High performance 95% vulnerable adults do not experience repeat maltreatment.	CY20 96.6%	CY21 97.1%	This measure was retired in September 2022

Fiscal Detail:

The cost of this budget proposal includes the costs for increasing and maintaining state supervision of Adult Protective Services, operation of the common entry point, and management of data.

This proposal includes ten FTEs at DHS. Investments of this size require sufficient administrative resources to ensure that public dollars are managed efficiently, effectively, and with the oversight needed to maintain program integrity. Hiring will occur in phases with four FTEs in FY2024, six FTEs in FY2025, and ten FTEs in FY2026. Staffing will include:

- Four (4) FTE for APS training and communications, including 1 supervisor, 1 e-learning, 1 advanced practice, 1 awareness and reporting
- One (1) FTE Resource Specialist to provide support for adult protection multidisciplinary teams and coordination of regional communities of practice.
- One (1) FTE for fiscal policy and to manage state and federal adult protection grants
- One (1) FTE to develop RFP's and manage projects for the MAARC and adult protective services
- One (1) Data and Analytics Supervisor

- One (1) FTE data analyst to develop and manage dashboards
- One (1) FTE data analyst for outcomes of adults reported to MAARC

This proposal also includes funding for enhancements to the Social Services Information System (SSIS) to improve equity analysis and funding for the maintenance and operation of the vulnerable adult data mart.

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			12,046	13,053	25,099	14,269	14,376	28,645
HCAF								
Federal TANF								
Other Fund								
Total All Funds			12,046	13,053	25,099	14,269	14,376	28,645
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	14	ADSA Admin	692	1,090	1,782	1,794	1,765	3,559
GF	REV1	Admin FFP @ 32%	(399)	(527)	(926)	(752)	(744)	(1,496)
GF	53	Grants to Counties, tribes, urban members	9,160	9,895	19,055	10,631	10,757	21,388
GF	11	Systems Costs, MAARC	1,730	1,730	3,460	1,730	1,730	3,460
GF	14	ADSA MAARC P/T Cost increases	554	556	1,110	557	559	1,116
GF	11	Systems Costs, SSIS	309	309	618	309	309	618
		Requested FTE's	**23**	**23**		**23**	**23**	
Fund	**BACT#**	**Description**	**FY24**	**FY25**	**FY24-25**	**FY26**	**FY27**	**FY26-27**
GF	14	ADSA Admin	4	6		10	10	

Statutory Changes:

256M.42

Change Item Title: Improving the MA Experience for People with Disabilities

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	5,557	2,970	2,970	2,970
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	5,557	2,970	2,970	2,970
FTEs	**22**	**22**	**22**	**22**

Recommendation:

The Governor recommends making resource investments to improve the experience of people with disabilities who apply for and are enrolled in Medical Assistance (MA). This proposal would require an investment of $8,527,000 in FY2024-2025 and $5,343,000 in FY2026-2027.

Rationale/Background:

Minnesotans who apply for health care programs may qualify for Medical Assistance for people who are age 65 or older, who are blind or who have a disability (MA-ABD). To have eligibility determined under this basis, a person must be age 65 or older or must have been formally determined to have a disability.

The State Medical Review Team (SMRT) performs disability determinations that establish a basis of eligibility for MA. SMRT completes disability determinations according to criteria defined by the Social Security Administration (SSA). Counties submit referrals to SMRT when a disability determination is necessary for eligibility.

A certification of disability, often referred to as a "SMRT determination," establishes a basis of eligibility for: Medical Assistance (MA), Minnesota's Medicaid program, home and community disability waiver programs (CAC, CADI and BI), MA under the TEFRA (Tax Equity Fiscal Responsibility Act) Option, and MA for Employed Persons with Disabilities (MA-EPD). It allows individuals to be excluded from managed care or voluntarily enroll in Special Needs Basic Care (SNBC). A SMRT certification of disability also gives people access to the Family Support Grant (FSG), which provides state cash grants to families of children with certified disabilities. All of these programs are important services for individuals and their families, especially those individuals seeking to leave hospitals and other restrictive settings. In state fiscal year 2021, the average time from receipt of a referral to a disability decision was 88 days.

SMRT processed approximately 7,000 cases in FY2021 including new and continuing disability reviews. The majority of referrals processed by SMRT are for CADI waivers (66% in FY2021). The November 2021 forecast projects that CADI enrollment will increase by 3.7% over the next biennium, resulting in an average of 1,171 new applicants annually and shows a projected increase of DD waiver applications of 3.9% over the next biennium, resulting in an additional 900 cases per year. Altogether, this will result in an increase to the SMRT referrals of approximately 2,900 cases per year, representing a more than 40% increase in workload. The SMRT team also anticipates increased referrals with COVID unwinding as there will likely be more applicants seeking SMRT certifications for programs who may not meet disability criteria. With projected increased caseloads due to CADI waiver and DD waiver referrals, it is expected that there will also be an increase in appeals – which have already almost doubled in two years.

Both the SMRT and eligibility determination processes for MA-ABD are largely manual, paper-based processes, which can result in delays for applicants and enrollees. The investments in this proposal would help move toward parity for MA-ABD enrollees with the experience of enrollees with other MA bases of eligibility and MinnesotaCare enrollees.

Additionally, this proposal would implement recommendations from the December 2020 Legislative Report: "Stakeholder Recommendations for Improving Medical Assistance under the TEFRA Option," to proactively inform parents about the Tax Equity and Fiscal Responsibility Act (TEFRA) option for their children with disabilities who are determined ineligible for Medical Assistance (MA) based on family income.

Proposal:

This proposal seeks to invest in program improvements for people with disabilities who apply for and enroll in Medical Assistance (MA).

State Medical Review Team (SMRT) Staffing

This proposal provides funding for SMRT to hire 14 new FTEs to accommodate increased projected program enrollments and increased appeals. The 14 new FTEs will include:

- 3 MAPE 8L Case Specialists;
- 8 MAPE 14L Disability Analysts;
- 1 MAPE 17L Appeals and Policy Lead;
- 1 MMA 18K Disability Analyst Supervisor, and;
- 1 MMA 18K Case Specialist Supervisor.

FTEs are assumed to begin work in October 2023.

SMRT Technology Investments

This proposal invests in upgrading SMRT's Integrated Services Delivery System (ISDS) Cúram system. SMRT uses an IBM Cúram Social Program Management (SPM) system (called ISDS) for all case management activity. SMRT is currently using version 7.0.0.1. IBM Cúram SPM is adopting a new release and support strategy, and standard support for version 7.0 will end April 30, 2023. Support extensions will not be offered. SMRT needs to upgrade to ISDS version 8.0 in order to retain IBM supports. It is estimated this upgrade will cost $1,462,392 and take approximately 13 months to complete. State share is estimated at 38%, and ongoing costs are assumed at 20% of up front costs. Completing this system upgrade ensures that this information will be stored in the most current version of Cúram with up-to-date security patches and software enhancements.

Improving support for families with disabled children seeking MA via the TEFRA Option

This will implement recommendations made by stakeholders included in the TEFRA Legislative Report published December 2020. This proposal will fund changes to the METS system to inform parents about the TEFRA option and Home- and Community-based (HCBS) waivers, when their children with disabilities are determined ineligible for MA based on family income.

The TEFRA option is an MA program supported in MAXIS; however there are a changes required in METS to help ensure an eligibility determination for the TEFRA option occurs when it is warranted. Changes to METS would include:

- Add TEFRA information for consumers to the online application;
- Add information about the TEFRA option and HCBS waivers to the eligibility results consumers see online;
- Add information about the TEFRA option and HCBS waivers to eligibility notices for children with disabilities who are determined ineligible for MA based on family income;

- Create a report to identify children with disabilities who may be eligible for the TEFRA option or a HCBS waiver program; and
- Create an automated task in METS to generate a referral for a TEFRA determination.

DHS requests three FTEs to carry out this work:

- 1 FTE (Health Care Eligibility & Access) will serve on the IT project, craft and maintain targeted communications about the TEFRA option for families and providers including schools, and provide ongoing supports as the community engagement liaison to stakeholders for children who have disabilities.
- 1 FTE (Health Care Eligibility and Operations) will develop and coordinate worker and assister training, develop worker facing communications and instructions, monitor the METS-generated reports for this population and ensure appropriate follow up with families occurs timely.
- 1 FTE (Health Care Eligibility and Access) will respond to increased workload in the State Medical Review Team (SMRT) business area related to reviewing TEFRA applications, making determinations of disability and assessing level of care.

Streamlining MA-ABD Eligibility Processes

Currently, MA cases for Minnesotans who are age 65 or older or who are blind or have a disability are maintained in MAXIS, a legacy mainframe eligibility system. The maintenance of cases for these populations involves many processes that are antiquated and manual and fall short of the current standards expressed in federal regulations and available in modernized systems. Among these processes are:

<u>Renewals</u>

- Federal regulations require states to attempt to renew eligibility annually based on information from trusted electronic data sources available to the agency before reaching out to the enrollee. This is called an “ex parte” renewal. We are currently unable to complete ex parte renewals for MA-ABD enrollees. This is burdensome to enrollees and introduces the potential for some enrollees who are otherwise eligible to lose eligibility simply for failing to complete the renewal process.
- Federal regulations permit and Minnesota statutes require the use of a pre-populated renewal form for MA enrollees who are age 65 or older, who are blind or who have a disability. We currently do not use a pre-populated form for these enrollees whose MA cases are maintained in MAXIS. Pre-populated forms reduce the burden on enrollees in maintaining their coverage and improve data integrity by communicating to the enrollee the eligibility-related information currently on file.
- Currently, the renewal process relies on the use of paper documents, handled primarily through the mail. This process is slow. Allowing enrollees to complete and submit their renewal online would greatly speed the process and improve the enrollee experience by providing another option for the completion of renewals.

<u>Verifications</u>

- Federal regulations require states to use available electronic sources to verify eligibility before requesting paper documentation from the applicant or enrollee. Currently, MAXIS makes only very limited use of electronic sources to verify financial information. Verifying information electronically would simplify the program and reduce the burden on enrollees.
- Electronic sources are available for the electronic verification of assets such as bank accounts. Minnesota currently uses the Account Validation Service (AVS) to obtain information about unreported accounts but does not use the service as a form of electronic asset verification. Adopting AVS as a form of electronic asset verification would simplify the program and reduce the burden on enrollees. In addition, there are other electronic services that could be adopted as sources for electronic verification of assets.

Changes in Basis of Eligibility

- Enrollees sometimes experience changes in circumstance that require that their MA eligibility be redetermined according to another basis of eligibility. Currently, when people must be redetermined under a basis of eligibility that is maintained in another eligibility system, there is no interface between the systems that automates the referral process. Automating this referral process would make it easier and faster for enrollees to be redetermined under all bases of eligibility when they experience a change in circumstances.

DHS requests 3 FTEs to streamline MA-ABD eligibility processes:

- 1 FTE (MAPE 17L) will serve as the eligibility policy expert resource, conduct research, and develop, implement, support and maintain the eligibility policies for these changes. This FTE will conduct ongoing community engagement, seeking input and feedback from stakeholders during and following implementation, particularly those from and focused on underserved communities. This FTE will review and approve worker and enrollee facing materials, respond to inquiries, present to internal and external groups and provide interpretations for trainers, systems staff and others.
- 1 FTE (MAPE 14L, Human Service Program Rep 2, OAT) will serve as the operational business lead on the IT project to ensure MHCP deliverables including business requirements, design documents, communication plans, test plans, and workflows. This FTE will serve as the ongoing technical and operational expert for maintenance and daily operations.
- 1 FTE (MAPE 11L, Human Services Program Rep 1) will develop, implement and maintain eligibility worker and assister training, draft, implement and maintain procedures and systems instructions, draft eligibility notices, and perform other project work.

Altogether, adopting these changes would help move toward parity for MA-ABD enrollees with those enrollees whose cases are maintained in METS. It would greatly speed and simplify application and renewal processes for applicants and enrollees, and simplify program administration for counties and tribes. It would also move Minnesota into better compliance with federal regulations, and increase data integrity in MHCP eligibility systems. An investment in modernizing MA-ABD would save time for county and tribal workers processing cases, decrease the number of cases needed to be worked by county and tribal workers, and reduce program churn for enrollees.

This proposal also includes permanent funding for the two FTEs in the COVID unwinding proposal (HC-64) who will be conducting disability determinations for those enrollees who have become eligible for MA under a disability determination. Funding for these staff members is assumed to begin in May of 2024.

Impact on Children and Families:

This proposal will simplify administration of the program, and application and renewal processes will be completed faster. There would be reduced risk of closures due to failures to return forms or verifications.

SMRT's current average processing time for processing cases is eight weeks. Increased referrals without additional FTEs will result in significantly longer wait times in access to services for some of Minnesota's most vulnerable population, including people who are trying to get out of hospitals.

Increased appeals without adequate staffing could result in delayed administrative hearings, which impedes applicants' due process.

Improving administration of the TEFRA option, enabling families to better navigate its application and renewal processes, and reducing disparities confronted by people with disabilities and their families.

Equity and Inclusion:

The enrollees served by SMRT are among the most vulnerable population of Minnesotans with a wide variety of physical and mental health impairments and social determinants of equity including language, geography, social-

economic conditions, education level, literacy, employment status, social justice inequities, housing status, immigration status, transportation, environmental, access to healthcare and communication, mental or behavioral health, age, and LGBTQ+.

51.1% of African Americans and other Minnesotans of color get their health care through MHCP. A 2021 analysis of 2018- 2019 data by the University of Minnesota's State Health Access Data Assistance Center (SHADAC) showed that approximately 41.5% of Black, 39% of Native American/Alaskan Native, 29.5% of Hispanic and 20.2% of Asian Minnesotans rely on Medicaid for health care coverage. Analysis of 2018-2019 data on Minnesotan children 0-18 years old who rely on Medicaid revealed that 64% of Black children, 59% of Native American/Alaskan Native children, 49% of Hispanic children, and 33% of Asian Minnesotan children rely on Medicaid, percentages that likely increased during the pandemic.[1]

Implementation of the TEFRA recommendations included in the TEFRA Stakeholder Legislative Report (mn.gov), published in December 2020, will reduce barriers experienced by families of children with disabilities who are seeking financial assistance for health care coverage that meets their children's often complex needs. People of color are disproportionally impacted by the multi-step application and renewal processes needed to qualify for and maintain TEFRA, and people of color are disproportionately impacted by the lack of targeted communication to providers including schools who are often the first points-of-contact for families with children with disabilities. Implementing this proposal will assuage these disparities.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Simplifying and streamlining program administration would ease the administrative burden for our tribal partners. Workers would need training in the use of new systems and processes. Additionally, while SMRT has traditionally not received referrals from tribal nations, moving forward, White Earth Nation and Red Lake will be submitting referrals to SMRT directly.

Impacts to Counties:

Simplifying and streamlining program administration would ease the administrative burden for our county partners. They would need training in the use of new systems and processes.

IT Costs

IT costs in this proposal total $3.306 million in up-front costs, with ongoing costs estimated at $661,000 per fiscal year. Changes are required in METS (for ISDS Curam upgrades) and MAXIS.

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of SMRT cases reviewed	7,000	FY21	7,000	9,900	FY24
Quality	Pre-populated forms used for renewal	0%	FY21	0%	100%	FY24

[1] Building Racial Equity into the Walls of Minnesota Medicaid: A focus on U.S.-born Black Minnesotans (state.mn.us)

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			5,557	2,970	8,527	2,970	2,970	5,343
HCAF					0			0
Federal TANF					0			0
Other Fund					0			0
Total All Funds			5,557	2,970	8,527	2,970	2,970	5,343
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	13	HCA Admin - FTEs (22, 22, 22, 22)	2,687	3,271	5,958	3,271	3,271	5,664
GF	REV1	FFP @ 32%	(860)	(1,047)	(1,907)	(1,047)	(1,047)	(1,812)
GF	11	State Share of Systems Costs	3,730	746	4,476	746	746	1,492
GF	11	OPS Admin	0	0	0	0	0	0
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	13	HCA Admin - FTEs (22, 22, 22, 22)	22	22		22	22	

Change Item Title: Tribal Elder Office

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	567	660	660	660
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	567	660	660	660
FTEs	**6**	**6**	**6**	**6**

Recommendation:

The Governor recommends investing $1.227 million in FY 2024-25 and $1.320 million in FY 2026-27 from the general fund to establish a Tribal Elder Office in the Department of Human Services (DHS). A dedicated Tribal Elder Office within the department promotes a true government-to-government relationship and demonstrates respect for the sovereign status of Minnesota's federally-recognized Tribal Nations.

The Tribal Elder Office will meet the current need to provide technical advice and support to each of the 11 Tribal Nations to assume authority and resources for supporting their elders and members with disabilities.

The purpose of this proposal is to support the implementation of MN Statute 10.65 through:

- Building technical expertise to maximize federal funding available to tribes
- Building capacity in tribes to provide long-term care services and supports (LTSS) to their members
- Maximizing each of the Tribal Nations' ability to directly access and utilize federal funding
- Increasing Tribal Nations' ability to provide vulnerable adult/developmental disability targeted case management, and
- Convening and facilitating a Tribal/State Long Term Services and Supports Workgroup to identify and implement tribal priorities for their service infrastructure and capacity.

There is no relative base for this proposal.

Rationale/Background:

In 2019, Governor Walz signed Executive Order 19-24, affirming the government-to-government relationship between the State of Minnesota and the eleven federally-recognized tribes in Minnesota's geographic area, and demonstrating commitment to meaningful consultation with the tribal communities and our state.

Pursuant to Executive Order 19-24[1]:

"The United States and the State of Minnesota have a unique legal relationship with federally recognized Tribal Nations, as affirmed by the Constitution of the United States, treaties, statutes, and case law.

[1] EO 19-24 was codified in Minnesota Statutes in 2021 (refer to MS 10.65)

"All agencies must recognize the unique legal relationship between the State of Minnesota and the Minnesota Tribal Nations, respect the fundamental principles that establish and maintain this relationship, and accord Tribal Governments the same respect accorded to other governments."

1. Establish a Tribal Elder Office

Despite its reputation as being one of the healthiest states in the nation, American Indians experience the worst health outcomes and disparities in Minnesota than any other population[2]. These disparities are products of structural racism and historical practices that were designed to erase the rich cultural heritage of indigenous peoples. As Minnesota state agencies seek to fulfill the commitment of Minnesota Statute 10.65, dedicated positions and administrative resources are necessary to promote "collaboration on matters of mutual interest and help to establish mutually respectful and beneficial relationships between the State and Minnesota Tribal Nations."[3]

This historic lack of resources has led to an inability for Minnesota to maximize tribes' ability to directly access federal funds. The complex interactions between funding and compliance requirements vary across different federal agencies and programs, such as the Administration on Aging/Administration for Community Living, Centers for Medicare and Medicaid. DHS does not currently have the depth of technical expertise necessary to support tribes to navigate and access the varying complex programs.

One primary strategy to fulfill its legal obligation to Minnesota's Tribal Nations is to provide dedicated and tailored technical advice and support to each of the 11 Tribal Nations to assume authority and resources for supporting their elders and members with disabilities. This request is supported by multiple requests to DHS over the years, from tribal summits in 2020, 2021, 2022, where nearly all tribes identified, among other things, a crucial gap in "dedicated staff to run the elder services office and to help direct them to the correct programs."

In addition, many tribes expressed their desire to exercise their sovereignty by reducing or eliminating reliance on using counties or other state entities as fiscal intermediaries for federal funding in previous tribal summits. In this case, the Area Agencies on Aging. Tribes noted in particular that they have challenges or are unable to fully utilize Title III funding under the Older Americans Act.

A brief background: Older Americans Act: Title III versus Title VI

The Older Americans Act (OAA) was enacted by Congress in 1965 in response to concerns about a lack of community social services for older adults[4]. Since its inception, the OAA has supported a wide range of social services and programs, ranging from senior nutrition and supportive services, to family caregiver support – primarily for low-income adults over 60 or older.

The OAA was amended in 1978 to include Title VI, which authorized funds for nutrition and supportive services to older Native American populations[5]. Eligible tribal organizations receive grants in support of the delivery of home and community-based supportive services for their elders, including nutrition services and support for family and informal caregivers[6]. Allocations for OAA Title VI started in 1980. This coincides with the creation of the Minnesota Indian Area Agency on Aging and serves four Tribal Nations: Bois Forte, Grand Portage, Leech Lake and White Earth.

Not all tribes currently have access to Title III funds under the OAA in Minnesota. Title III must funnel through numerous state and federal layers before reaching tribes. Comparatively, Title VI funds don't require the tribes to

[2] Advancing Health Equity in Minnesota: 2014 Report to the Legislature (state.mn.us)
[3] EO 19-24, p. 1
[4] Older Americans Act | ACL Administration for Community Living
[5] Older Indians (acl.gov)
[6] Services for Native Americans (OAA Title VI) | ACL Administration for Community Living

interact with the state, counties or Area Agencies on Aging to access the federal funding already available to them[7]. For tribes that do not yet have access to Title III funds, the current practice not only reduces the amount of funds tribes ultimately receive, but it also creates an additional and unnecessary pass through from the Area Agencies on Aging to the tribes.

With the establishment of the dedicated staff in this proposal, the state will have the essential resources to enable all tribes in accessing the OAA Title III grants. These dedicated positions are necessary to provide the level of technical expertise required to access these funding sources, as well as continue building collaborative relationships between DHS and the Tribal Nations within Minnesota.

2. Tribes as direct providers for targeted case management

This second strategy seeks to eliminate statutory barriers to elevate tribal sovereignty and support the individual tribal member to be supported by the respective tribal nation. This will be achieved through removing the barrier that currently exists in state statute, which currently prohibits tribes from providing targeted case management services to their members.

Targeted case management services are designed to decrease the need for more costly services such as multiple emergency room visits or hospitalizations by linking people with medical, social, educational, and other services. Tribes are in the best position to provide effective and culturally appropriate targeted case management for their members.

3. Tribal LTSS Workgroup

A third strategy for the department is to create the Tribal/State Long Term Services and Supports Workgroup to establish a formal venue to support tribes in identifying their key priorities and issues related to funding and services. In 2019, DHS and tribes came together and developed a shared understanding and vision for tribal LTSS, with the goal of increasing access to services and participation in LTSS programs among American Indian vulnerable adults and elders.

Convening and facilitating a Tribal LTSS Workgroup to identify and implement tribal priorities for their service infrastructure will help shift the power and resources to the tribes to serve their elders and people with disabilities the way they know best to do.

Proposal:

This proposal establishes a Tribal Elder Office in the Aging and Disability Services Administration at the Department of Human Services. Ultimately, this proposal aims to promote and facilitate the sovereignty of the tribal nations in Minnesota through technical assistance and dedicated staff who will support tribes by delivering tailored support to bolster tribes' ability to offer services that reduce health inequities and increase access to culturally-appropriate health care for their members.

This specific level of technical assistance is necessary to support tribal social services agencies in overall knowledge about support services available, as well as to develop trusting professional relationships with the tribal nations. Currently, tribal relations and policy development are small components of other policy positions in the Aging and Disability Services Division. Dedicated, full-time positions are required to work with tribes to make fundamental changes to how they access federal funds and serve their members. The initial priorities of the Tribal Elder Office will be:

- Analyzing mechanisms for the Tribal Nations to directly access Title VI, which allows for federal appropriations directly to tribes.

[7] Older Americans Act: Overview and Funding | June 2022 | (congress.gov)

- Operationalizing the statutory amendment that will support the Tribal Nations ability to contract with counties to provide vulnerable adult/ developmental disability targeted case management.
- Launching the Tribal/State LTSS workgroup to establish a venue for consistent collaboration and support driven by the needs of the Tribal Nations.

This proposal includes the following resources:

Dedicated Technical Assistance (2 FTE)
One advantage of having dedicated policy liaisons is to establish relationships, which will lead to gaining insight and knowledge of local programs. A deeper understanding of the local programs not only lends itself to the development of trusting relationships, but also positions staff to better support tribes with more specific and actionable recommendations.[8]

This proposal includes two policy staff who will serve as dedicated points of contact for the tribes and provide one-on-one technical assistance. These staff will serve as subject matter experts in areas such as Medicaid waiver policy and the OAA to help tribes improve access existing programs and resources. These staff will be steeped in policy expertise and will act as liaisons and to provide support through TA tailored to the unique needs of each tribe. Enhanced and in-depth training and technical assistance is needed to provide tribes with the tools they need to serve their elders well and in a culturally responsive way.

ADSA Supervisor and System-wide Coordination (3 FTE)
- 1 FTE (17L) - Coordinator - Lead agency review, gaps analysis, MNCHOICES, and tribal LTSS workgroup
- 1 FTE (17L) - System-wide policy lead (focus on the overall systems design)
- 1 Unit Supervisor (Supervisor 4)

Grants Capacity Building (1 FTE)
This proposal includes one grants administrator to support tribes in building capacity by assisting with the application for federal grants. One primary function of this position is to assist tribes with applying for existing federal grants that will support FTEs for tribes to build their organizational capacity. This will provide the critical infrastructure necessary for tribes to take full advantage of federal funding opportunities.

Impact on Children and Families:

American Indian women, children, and families experience the greatest health disparities in Minnesota[9]. This proposal facilitates resources for tribes to design and implement a wide variety of community services and initiatives that support overall community health, including children and families. While OAA Title VI funding is focused on elders, other federal grant programs target broader populations. Improving tribal capacity to leverage new resources will benefit children and families.

Equity and Inclusion:

While Minnesota consistently ranks as one of the healthiest states in the country, significant and longstanding disparities in health outcomes for American Indians and other racially minoritized groups are evident over many years because the opportunity to be healthy is not available everywhere or for everyone[10]. By creating a Tribal Elder Office, the department will be able to support individual Tribal Nations to craft grant proposals, as well as access other federal funding streams, to reduce disparities in their communities and improve overall community health. Individual tribes are in a better position than DHS or counties to determine what initiatives and programs are most likely to reduce disparities in their communities and improve outcomes.

[8] Evaluation Of The ACL Title VI Programs: Final Report
[9] American Indian Maternal and Child Health (state.mn.us)
[10] Social and economic factors: American Indian health status in Minnesota [30-year retrospective] (mn.gov)

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Tribal governments will be positively impacted by this proposal because they will have the option to work with the department to access new federal resources to meet their community needs and design the use of those resources in a culturally appropriate manner. Over time, tribes will build internal capacity to do this work and reliance will be reduced on other governmental agencies; they will no longer be forced to rely on other governments to play a gatekeeping role relative to securing federal funding. Tribal Nations will no longer be required to work through a county to provide targeted case management services to their members.

Tribes have consistently expressed a strong desire to have the resources to reduce reliance on counties and identified a need for dedicated resources in DHS to support this work. This proposal is building off of multiple years of feedback we've heard at the Tribal Legislative Summit, during several tribal consultations, and was also developed in collaboration with the DHS Office of Indian Policy.

Working with the Office of Indian Policy, the department will bring this proposal to tribal nations and ask for input on what types of support and technical assistance is most needed for that particular tribe. The positions funded by the proposal will be assigned as dedicated liaisons to a particular tribe. Over time, this will allow for the deepening of government-to-government relationships and help DHS understand the needs of tribes with more depth and clarity.

Impacts to Counties:

This proposal is expected to reduce administrative burdens on the counties that are currently acting as fiscal intermediaries for federal funding. As tribes build capacity to access federal funding, county workload will reduce overall. Counties may benefit or learn from tribes that develop innovative service models with this funding that could be replicated by county agencies. It will be easier for counties and tribes to collaborate as partners because tribes will not have to manage the power dynamic of relying on counties to maintain and access federal funding, and will be able to contract with counties to provide targeted case management for their elders and members with disabilities.

County engagement has not yet formally taken place, but is planned through vetting this proposal with MACSSA the county-state work group.

However, it should be noted that some county engagement has occurred, particularly with counties that have been directly engaged in closest proximity to the respective Tribal Nations' interest in providing VA/DD TCM to their members, as well as in providing capacity in the department's end to facilitate the development of the tribal LTSS infrastructure.

IT Costs:

There are no IT costs as a result of this proposal.

Results:

Success/performance measures will be established to track and monitor whether or not tribes apply for and receive new grants funds. When DHS is successful in activating title VI funds under the OAA, the impact to this proposal will also be measured by increasing the number of tribes/members that access title VI funding. A key component of the technical assistance DHS will provide to tribes will be establishing program or initiative performance/evaluation metrics so that tribes will monitor and evaluate their initiatives to determine if their members are better off as a result of the initiative.

Fiscal Detail:

The cost of this proposal includes the costs for establishing a new Tribal Elders Office focused on increasing tribal capacity and serving as a technical resource.

The costs include:

- 1 Unit Supervisor (Supervisor 4)
- 2 Policy staff/waiver SME's staff to support tribes in developing human services programs (i.e. become a lead agency) and capacity building to serve Tribal members:
  - 1 FTE (14L) - EW, AC, ECS SME
  - 1 FTE (14L) - Disability waivers, CFSS/PCA, EIDBI
- 1 FTE (17L) - Policy lead/Coordinator (focus on the overall systems design, gaining access to Title VI for all Tribal Nations, etc.)
- 1 FTE (17L) - Coordinator assessment/systems lead (agency review, gaps analysis, MNCHOICES, and tribal LTSS workgroup)
- 1 FTE (14L) - Grant administrator/technical assistance for grant applications
  - CMS offers Tribal Initiative grants – once the department has resources to assist tribes in applying for these federal grants, those staff will provide the support to get the FTEs for tribes to provide the capacity and build infrastructure on their end

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			567	660	1,227	660	660	1,320
HCAF								
Federal TANF								
Other Fund								
Total All Funds			567	660	1,227	660	660	1,320
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	14	ADSA Admin FTE (6, 6, 6, 6)	834	971	1,805	971	971	1,941
GF	REV1	Admin FFP @ 32%	(267)	(311)	(578)	(311)	(311)	(621)
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	14	ADSA Admin	6	6	6	6	6	6

Statutory Changes:

Tribes allowed to contract with counties to provide targeted case management services – 256B.0924

Change Item Title: EIDBI Culturally Responsive Rate & Licensure Study

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	239	263	23	23
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	239	263	23	23
FTEs	**1**	**1**	**0**	**0**

Recommendation:

The Governor recommends improving access to culturally responsive services for American Indian communities by improving access to payment incentives for American Indian providers of Early Intensive Developmental Behavioral Intervention (EIDBI). The Governor also recommends that the Department contract with a third party to study licensure options for the EIDBI service.

This proposal invests $501 thousand in fiscal years 2024-25 and $46 thousand in fiscal years 2026-27.

Rationale/Background:

American Indian Culturally Responsive Rate

Early Intensive Developmental and Behavioral Intervention (EIDBI) is a Medical Assistance (MA) benefit that provides medically necessary services for people under the age of 21 with autism spectrum disorder (ASD) and related conditions. Autism is the fastest growing neurodevelopmental disability in the United States; diagnoses have increased by 240% since the year 2000. Minnesota's prevalence rate ranks second in the country according to recent CDC data, with 1 in every 36 eight-year-old children identified with ASD.

EIDBI providers are reimbursed based on a tiered set of qualifications, which include education and experience criteria. Currently, providers are eligible to receive a higher reimbursement rate if they are fluent in a non-English language. This policy was enacted to incentivize providers who serve historically marginalized communities to provide EIDBI.

Although ASD occurs in all racial, ethnic, and socioeconomic groups, cultural differences vary between American Indian and Indigenous, African American, African-born, Hispanic, Latinx, Asian, and eurocentric communities. In autism diagnosis and treatment, it is important that providers understand these differences, which include communication styles, eye contact, and play norms. There is also increased stigma and fear about accessing medical services and supports in many of Black, Indigenous and People of Color communities due to a history of abuse and discrimination in the healthcare field. This leads to disparities in American Indian children being screened and identified for ASD in a timely and equitable manner.

Licensing Study

EIDBI services are provided by qualified providers through Minnesota's public health care programs (MHCP). EIDBI services are not licensed or certified. DHS Provider Enrollment and Compliance (PEC) conducts a site visit prior to enrollment, another site visit after 1-2 years, and again at five years. Additional oversight is triggered if a report of fraud occurs. Without a license, DHS has limited regulatory oversight, save for payment suspension or

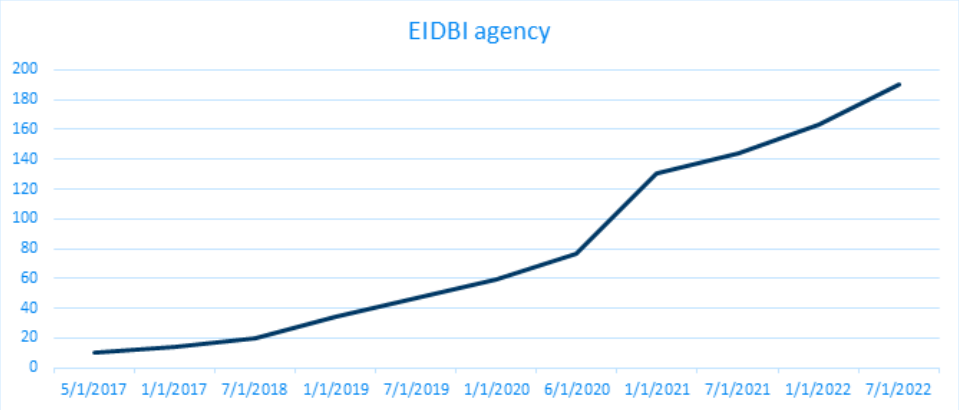
termination. There is no process for corrective actions or regular visits to ensure the integrity of the clinical programming and physical plant standards.

As the benefit has grown, thousands of Minnesota's youngest and most vulnerable children have received services through EIDBI. Children may receive seven hours or more of therapy a day, in a location with no legal safety requirements, such as cleaning procedures, number of bathrooms, child proofing requirements, or other health, safety, and other therapeutic guidelines.

EIDBI providers utilize treatment modalities as outlined in the EIDBI statute, including Applied Behavioral Analyst (ABA), Developmental Individual-difference Relationship-based model (DIR/Floortime); Early Start Denver Model (ESDM), PLAY project, and Relationship Development Intervention (RDI). ABA is the most widely used modality under the benefit. Nationally, there has been increasing concern about ABA abuse, fraud, and waste, including an announcement by the United States Department of Health and Human Services Office of the Inspector General in June 2021 to audit ABA providers throughout the US in 2022. These concerns are garnering national media attention and a report to Congress. Minnesota's lack of licensure or credentialing process creates opportunities for imposter providers who are not actually qualified to provide ABA services to harm Minnesota children with autism and exploit loopholes in enforcement of Minnesota MA payments.

Currently there are over 190 EIDBI providers, with rapid expansion that occurred during COVID-19 when no site visits were being conducted. Many of these agencies have not yet had a site visit.

Growth in number of EIDBI agencies in Minnesota



Proposal:

This proposal includes two components. The first part of the proposal is to increase culturally responsive EIDBI services to participants and families by specifying that American Indian EIDIBI providers, regardless of non-English language fluency, would be eligible to receive a higher reimbursement rate, consistent with their ability (i.e. member of a tribal nation or specific training in American Indian culture and history) to meet the unique needs of American Indian children and youth. This would expand current EIDBI provider qualifications to increase access to culturally competent services for American Indian children.

In conversations with tribal members and providers who served on the EIDBI Advisory Group, DHS became aware that this policy largely barred American Indian providers from receiving the higher reimbursement as many tribal members are no longer fluent in their native language due to forced assimilation laws and practices that enforced English as the official language on reservations and punished children for speaking their own language in boarding schools. The Administration of Native Americans report there are 245 indigenous languages in the United States, with 65 already extinct and 75 near extinction with only a few elder speakers left.

The second part of the proposal would allocate funds to contract with an outside vendor to complete a comprehensive licensure feasibility study for EIDBI. The study will examine the following topics and make recommendations:

- Current DHS licensed programs that may have similarities to EIDBI, such as childcare providers, 245D providers, and mental health programs;
- Licensure requirements/components in other autism programs throughout the United States;
- Health and safety needs for EIDBI programs;
- Potential fraud, waste, and abuse concerns; and
- Necessary resources for continued auditing and quality control oversight.

The vendor will be required to complete robust stakeholder engagement throughout the process.

Impact on Children and Families:

Children and young adults with autism spectrum disorder and related conditions will be directly impacted by this proposal. The EIDBI Advisory Group and other parent advocates have been consulted in the development of this proposal.

As previously noted, autism is the fastest growing diagnosis among children with disabilities in Minnesota, with the second highest prevalence rate in the country. Ensuring children across Minnesota are receiving high quality, safe, and culturally competent services is essential. As autism prevalence continues to increase, the importance of these services will continue to expand in its reach.

EIDBI assists children with autism and related conditions including fetal alcohol spectrum disorder (FASD) to increase their school readiness. Ensuring that children receive culturally appropriate services can increase the efficacy of EIDBI Services and lead to better long-term outcomes for children and families. When families have the skills to support their children with autism and related conditions, they can participate in their communities.

In Minnesota, American Indian students have one of the lowest graduation rates in the state. American Indian student four-year graduation rates across Minnesota were about 55% in 2020. This is compared to about an 85% statewide graduation rate. Many children of color and American Indian children who have autism are misdiagnosed or instead labeled as having behavioral issues and face suspensions, expulsions, and disparate treatment in our schools.

Equity and Inclusion:

American Indian communities have experienced profound trauma dating back to colonial settler policies, including genocide, to eradicate indigenous knowledge and culture. This history of trauma has resulted in intergenerational trauma. For example, children were forcibly removed from their homes and sent to boarding schools where they were neglected; children were physically and sexually abused; and denied the ability to speak their first language and practice their religion. This historical trauma impacts parenting and family dynamics today. American Indians experience higher rates of substance use disorder, PTSD, and suicide all of which are directly associated with this intergenerational trauma. [1]

A 2009 University of Minnesota study reported that American Indian and Alaska Native children with autism are 13 percent less likely to be identified than white children with the disability.[2] This is not to suggest ASD is less prevalent in Native communities; tribal children just are not being diagnosed, in part due to implicit bias resulting in misdiagnosis or under-diagnosis. Still, American Indian children are overrepresented in Minnesota's EIDBI benefit. Currently about 5% of EIDBI participants are American Indian compared to about 1% of American Indians in the overall population.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), providers need to understand how people they serve perceive their own cultural identity and how they view the role of traditional practices in treatment. Helping people maintain ties to their native cultures can help prevent and treat substance

use and mental disorders. Through reconnection to American Indian and Alaska Native communities and traditional healing practices, an individual may reclaim the strengths inherent in traditional teachings, practices, and beliefs and begin to walk in balance and harmony. Ensuring tribal members can access the culturally responsive EIDBI Level II and III rates will help incentivize tribal members to provide EIDBI services in Minnesota and improve the state's ability to ensure culturally responsive services 1

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

This proposal has important impacts for tribes, Indigenous people, and Native Americans. Reimbursing American Indian providers at a higher rate will increase the cultural responsivity of EIDBI services. DHS discussed this proposal with tribes at the 2023 tribal summit.

IT Costs

There are no IT costs.

Results:

Early Intensive Developmental and Behavioral Intervention

Currently DHS monitors the number of enrolled providers enrolled at three different reimbursement levels. The higher reimbursement level, Level I, coincides with more training, support and retention. Over the last year, there has been a steady increase in Level II providers, while Level III providers have remained stagnant. This growth may be explained, in part, by the change made in 2017 that allowed providers who were fluent in a non-English language to move to a higher reimbursement level. Therefore, it is anticipated that this proposal would result in similar growth, proportionate to American Indian provider population and potential provider population.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			239	263	502	23	23	46
HCAF								
Federal TANF								
Other Fund								
		Total All Funds	239	263	502	23	23	46
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	33	MA FC	4	23	26	23	23	46
GF	14	Admin DSD	200	200	400	0	0	0
GF	14	ADSA Admin FTE (1, 1, 0, 0)	145	153	298	0	0	0
GF	REV1	Admin FFP @32%	(110)	(113)	(223)	0	0	0
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	14	ADSA Admin	1	1	1	0	0	0

Statutory Change(s):

256B.0949, session law.

[1] https://www.psychiatry.org/psychiatrists/cultural-competency/education/best-practice-highlights/working-with-native-american-patients

[2] https://pop.umn.edu/sites/pop.umn.edu/files/racial_disproportionality.pdf

Change Item Title: Improving the assessment experience for people and lead agencies

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	1,957	2,220	2,250	2,250
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	1,957	2,220	2,250	2,250
FTEs	**3.25**	**3.25**	**3.25**	**3.25**

Recommendation:

The Governor recommends investing $4.177 million in fiscal years 2024-25 and $4.5 million in fiscal years 2026-27 to improve Minnesota's long-term services and supports assessment process for people receiving an assessment and lead agencies administering the assessment.

This proposal includes several components: (1) funding ongoing systems work to keep the MnCHOICES assessment modernized, (2) lowering the MnCHOICES assessor qualifications to attract more individuals to the work; and (3) funding a presumptive eligibility feasibility study for Medical Assistance (MA) financial and functional eligibility.

Rationale/Background:

Eligibility determinations for long-term services and supports involve two layers: (1) Medical Assistance (MA) financial eligibility and (2) functional eligibility determined by long-term care consultation (LTCC), also known as "MnCHOICES." Both systems have varying requirements which are often dictated by federal regulations and laws. Navigating these complex eligibility systems can be challenging for people and families. It can also result in delayed access to needed services and supports. To provide faster access to home and community-based services, some states have explored authorizing benefits during a presumptive eligibility period and accepting self-attestation as verification for financial and functional eligibility. Presumptive eligibility is an option that allows states to authorize certain qualified entities to enroll individuals who appear likely eligible for coverage while the state processes the full application and makes a final eligibility determination. Presumptive eligibility can facilitate access to coverage and services when individuals in need of critical services also may need extra time to collect documents needed to complete a full eligibility determination.

The state of Minnesota utilizes a single, comprehensive web-based assessment and support planning application to determine the eligibility of a person for several publicly funded programs and services called MnCHOICES. MnCHOICES is for people of all ages who have any type of disability or need for long-term services and supports. This assessment eliminated the need for multiple assessments to access appropriate supports and services. These programs include the Alternative Care Program, the Brain Injury Waiver, the Community Access for Disability Inclusion Waiver, Developmental Disabilities Waiver, Elderly Waiver, Essential Community Supports for Seniors, Moving Home Minnesota, Personal Care Assistances (soon to be called Community First Services and Supports), Case Management, Consumer Support Grant and Semi-Independent Living Services. This assessment reduces paperwork, enhances the process with a person-centered approach, includes the support planning process, promotes statewide quality measurement, promotes equal access across populations and geographic areas and supports matching services to an individual's strengths, preferences and needs.

DHS launched the MnCHOICES assessment in 2013 and the MnCHOICES support plan in 2016. In 2016, DHS began to plan and prepare for a revision to the MnCHOICES assessment to support assessors and update the application to ensure people's needs continue to be met through a person-centered process. As of January 2021, roughly 125,000 people received long-term services and supports, supported by an annual MnCHOICES assessment. Roughly 185,000 assessments are completed annually, and this number is growing with Minnesota's aging and disability population.

Proposal:

1) MnCHOICES Operational Budget. This proposal seeks to fund the ongoing state share of the operation costs for both MnCHOICES and ease certified assessor qualifications to allow lead agencies to hire a larger and more diverse pool of applicants. DHS is in the process of completing the production phase of the MnCHOICES application and will move into the operational phase in 2023. The application is eligible for Advanced Planning Document (APD) dollars from CMS which covers 75% of the operational costs if Minnesota can provide the required 25% match. MnCHOICES is supported by external vendors. The work that the vendors do is unable to be done internally by DHS or by MNIT. To ensure the systems are updated and supported as needed, ongoing annual funding is required.

This proposal also modifies current assessor qualifications to be lowered to allow someone without one year of Home and Community Based experience, but all other relevant education, experience and training to conduct a MnCHOICES assessment. This modification should allow lead agencies to hire from a wider and more diverse pool of applicants. Many lead agencies note that they have a difficult time filling certified assessor positions which is one factor that leads to long waiting lists to receive a MnCHOICES assessment.

MnCHOICES DHS Staffing Costs. DHS FTE costs represents portions of salary costs for over 30 staff responsible for operating MnCHOICES. This includes subject matter experts responsible for identifying and monitoring business requirements and system functions, and ensuring the system continues to align with policies. It also includes staff responsible for reporting, training, and communications about the system. Estimates are based on FTE costs in Q3 of FFY23 (April-June 2023) in the IAPD since this quarter represents the beginning of the transition from the development to operational phases. About 20% of these costs are needed for future enhancements.

MnCHOICES MNIT Costs. MNIT costs represent portions of salary costs for staff responsible for operating MnCHOICES. This includes business analysts, developers, project managers, and quality assurance testers to ensure the system continues to function as required. Estimates are based on FTE costs provided in the IAPDs for SFY2023.

FEI Contract costs. FEI contract costs represent future enhancements and changes requests. These include some changes needed for policy changes in current law, such as inflationary rate adjustments. It also includes change requests that may not be known and enhancements that would improve operations for DHS, lead agencies, and other users. About half of these costs are assumed to be future enhancements. This analysis also assumes that a future contract with FEI will include a $120,000 monthly operating fee.

Additional MNIT hardware, software, licensing, and contracting costs includes maintaining legacy systems during the transition. Legacy systems are expected to be retired after the first year and the maintenance cost will decrease accordingly. These costs account for increasing costs over time.

2) Presumptive Eligibility Study: The third component of this proposal is funding to conduct a presumptive eligibility feasibility study for Medical Assistance (MA) financial and functional eligibility. The study would provide DHS information and guidance on the feasibility of implementing a financial and functional presumptive eligibility policy. The primary goal of a presumptive eligibility process is to assist people during a time of urgent need (for example, waiting to discharge from an institutional setting) in obtaining immediate services and supports rather than waiting for the full financial and functional eligibility process (which would then occur after their services and supports have started.)

3) Business Solutions Staffing Cost: This proposal provides ongoing funding for state staff who manage systems transformation activities on behalf of the Aging & Disability Services Administration (ADSA). These staff are critical to ensure seamless delivery of services during transitions, as well as efforts to identify and develop innovative approaches and business solutions to meet ADSA's needs. In ADSA, this includes one 19M Manager that manages staff across both the ADSA and BHDH administrations, and one 17L staff.

Impact on Children and Families:

This funding and this policy change allows Minnesota to continue to operate a functional, statewide assessment tool that assures all people will be assessed appropriately for and get the services they need. Data on people receiving long-term services and supports show that 11.8% of participants are under 15 years of age and 7.8% of participants are 16-24 years old. More information can be found on the DHS LTSS demographic dashboard.

Equity and Inclusion:

The systems this proposal supports include home and community-based services (HCBS), including Community First Services and Supports (CFSS). The assessment process supported by this proposal determines the support range and services a person receiving HCBS requires. Data on people receiving long-term services and supports show that people receiving long-term services and supports are typically more diverse than Minnesota's overall population. In January of 2021, 18.5% of the population was African American/Black, 2.4% American Indian, 7.8% Asian or Pacific Islander and 2.8% were Hispanic. Ensuring continuity of care and ease of assessments for long-term services and supports not only increases the quality of life of people with disabilities and who are aging, but also increases equity for people who are black and indigenous.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

There are tribal governments in Minnesota that have contracted with the state to conduct MnCHOICES assessments and determine eligibility for the long-term services and supports programs. This proposal will impact tribes by financing the operation of the system and enabling tribes to hire a larger applicant pool for their assessors. Presumptive eligibility may also benefit tribal governments and members by speeding up the time people are able to access long term services and supports.

Impacts to Counties:

This proposal will impact counties administering MnCHOICES assessments by ensuring the MnCHOICES application is operational, as well as allow lead agencies to hire from a larger pool of qualified individuals. This proposal is expected to combat the workforce shortage through the updates to the assessor qualifications.

IT Costs

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029Just*
Payroll	878	900	900	900	900	900
Professional/Technical Contracts	375	705	735	735	735	735
Infrastructure						
Hardware	113	28	28	28	28	28
Software						
Training						

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029Just*
Enterprise Services						
Staff costs (MNIT or agency)						
Total						
MNIT FTEs	8.5	8.5	8.5	8.5	8.5	8.5
Agency FTEs	11	11	11	11	11	11

Results:

MnCHOICES has a systemic methodology in place to track results in the application. This allocation will fund future improvements and efficiencies within the application. Without this funding, the application is at risk of falling out of date and unable to manage changes to the home and community-based service system. And with a shortage of workers available to provide assessments, this proposal will help ensure that current assessors are able to meet the needs of people seeking home care and home and community-based services in Minnesota.

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	20 day timeline from date assessment was requested to date of assessment activity	N/A- we do not currently have this data available, but the revised MnCHOICES will capture it	Revised MnCHOICES launch is April 2023			
Quality	Number of certified assessors statewide	2,540	10/1/22			
Results						

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
General Fund			1,957	2,220	4,177	2,250	2,250	4,500
HCAF								
Federal TANF								
Other Fund								
Total All Funds			1,957	2,220	4,177	2,250	2,250	4,500
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	Systems: MnCHOICES	1,365	1,633	2,998	1,663	1,663	3,326
GF	14	ADSA FTE (BIA)	538	526	1,064	526	526	1,052
GF	REV1	Admin FFP	(279)	(277)	-556	(277)	(277)	-554
GF	14	ADSA Admin P/T Presumptive Eligibility	300	300	600	300	300	600
GF	11	Central Ops Admin (.25, .25, .25,.25,.25)	33	38	71	38	38	76
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	14	ADSA FTE	3	3	3	3	3	3
GF	11	Central Ops Admin	0.25	0.25	0.25	0.25	0.25	0.25

Statutory Change(s):

256B.0911, session law

Change Item Title: Nursing Facility Case Mix Classification Modification

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	82	35	35	35
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	82	35	35	35
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends reform to Minnesota's case mix classification system to support the transition of nursing home payment rates to a new state case mix system due to changes at the federal level. Statutory updates are required for DHS to properly process the nursing facility rates for private pay and Medicaid claims after CMS no longer supports the current system beginning October 2023. There will not be an impact to the forecasted program Medical Assistance (MA) rates to nursing facilities however there will be IT systems costs.

Rationale/Background:

In October 2019, the Centers for Medicare & Medicaid Services (CMS) changed the method that it uses to classify patients in a covered Medicare nursing facility stay from Resource Utilization Groups Version IV (RUG-IV) to the Patient-Driven Payment Model (PDPM). Minnesota still uses the RUG-IV system[1] for the determination of Medicaid reimbursement rates for nursing facilities. With the changed method to PDPM for Medicare payment at the federal level, Minnesota must assess options for a continuing case mix system for Medicaid and private pay payment rates after CMS no longer supports the RUG-IV system. That support is now estimated to end October 1, 2023.

The Department of Human Services (DHS) is currently contracting for an analysis of the PDPM and its suitability as a replacement for Minnesota's RUG-IV classification system and overall recommendations for a new Medicaid classification system. This analysis will inform Minnesota's new resident assessment case mix system DHS needs to establish both Medicaid and private pay payment rates after CMS no longer supports the RUG-IV system.

Proposal:

This proposal allows for the transition of payment rates to a new case mix classification system for nursing facility residents. The new system will have new case mix classifications and indices, and is necessary to properly process nursing facility Medicaid claims[2]. Statutory updates are necessary for DHS to properly process the nursing facility rates for private pay and Medicaid claims after CMS no longer supports the RUG-IV system beginning in October 2023.

The implementation plan for a new case mix system will be designed to be budget neutral relative to total payments that would have been made under the current RUG-IV system. However, funds will be needed for IT systems modifications to MMIS to allow for proper payment of Medicaid nursing facility claims. The modification

[1] In addition to two state-specific case mix groups

[2] The case mix system is used in adjusting nursing facility care related operating payment rates for acuity

to the case mix system will impact 360 Medicaid-certified MN nursing facilities. The effective implementation date of this proposal aligns with the current federal transition date of October 1, 2023.

Impact on Children and Families:
This proposal does not have a direct impact on children and families.

Equity and Inclusion:
This proposal is intended to comply with changes made by CMS to nursing facility case mix classifications, which affects all Medicaid-certified nursing facilities. The proposal will not have any discernable effect for racial and ethnic groups.

Public Engagement:
There has been significant discussion with the nursing home industry regarding the necessity to make the transition to a new case mix system. The industry will be active participants along with DHS staff and the hired contractor in development of the recommended modifications.

Impacts to Counties:
There will be no fiscal impact to counties with this proposal. This proposal does not impact county operations.

Impacts to Tribes:
This proposal does not have a direct impact to Tribal Nations.

Results:
This proposal is necessary to align MN Medicaid payment system with resident assessment changes at the federal level that affect payment for nursing facility stays.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Results	The ability to continue to pay for Medicaid nursing facility services provided on or after October 1, 2023.			Beginning October 1, 2023

IT Related Proposals:
This is not an IT proposal however there are one-time IT changes required to implement.

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll						
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)	$82	$35	$35	$35	$35	$35
Total	**$82**	**$35**	**$35**	**$35**	**$35**	**$35**
MNIT FTEs	0					
Agency FTEs						

Estimates are state share only. This projection assumes a systems cost to MMSI with a state share of 29% and a systems cost to the nursing facility classification system with a state share of 50%. The project also assumes federal matching for administrative costs at 32%.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			$82	$35	$117	$35	$35	$70
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$82	$35	$117	$35	$35	$70
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	Operations	$82	$35	$117	$35	$35	$70
		Requested FTE's	**0**	**0**	**0**	**0**	**0**	**0**

Statutory Changes: MS 256R.17 and 144.0724

Change Item Title: Technology Investments to Support Independent Living and Address HCBS Workforce Challenges

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	352	405	405	405
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	352	405	405	405
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The governor recommends increasing investments that support the use of technology to enhance independent living and reduce reliance on direct support professionals. This proposal has three components: (1) increase the existing technology for home grant by $300,000 per year to expand access; (2) expand the technology for home grant purpose to focus on reduction in staff for people living in community residential settings or own-home settings; and (3) Increase the specialized equipment and supplies (SES) waiver service limit from $3,909 to $10,000 per year. Investments in this proposal total $757 thousand in fiscal years 2024-25 and $810 thousand in fiscal years 2026-27.

Rationale/Background:

Through The Rehabilitation Act, the Technology Related Assistance for Individuals with Disabilities Act (The Tech Act), the Individuals with Disabilities Education Act (IDEA), and the Americans with Disabilities Act (ADA) of 1990, the federal government broadened state roles in increasing awareness and accessibility of assistive technology (AT) devices and services to adults and children with disabilities. The 2020 Legislature codified policy statements that indicate it is the policy of the state that adults and children with disabilities can use assistive technology and remote supports to enhance independence and quality of life and that DHS shall ensure that adults and children with disabilities are offered the opportunity to choose assistive technology or remote support.

Assistive technology and remote service provision have been identified as premiere solutions to assist with the workforce shortages plaguing the long-term care economic sector. Assistive technology allows people the ability to do things for themselves that they would otherwise need staff to do for them. It is also used heavily to enable the use of remote service provision which also increases people's independence and maximizes staffing resources.

The 2009 Minnesota Legislature invested in The Technology for Home grant (T4H). This grant is administered by the Department and has been delivered by one contractor since inception. It offers in-home assistive technology consultation and technical assistance services to help people with disabilities live more independently. Assistive technology is defined as a technology which can assist people with disabilities to better access their environment. It can be high-tech or low-tech. Examples of assistive technology include:

- Augmentative and alternative communication devices (used by people who are minimally verbal or non-verbal)

- Environmental control units (devices which facilitate access to devices such as lights, home temperature controls, television, computer, etc.),
- Wheelchair or wheelchair ramp
- Large-print books
- Tactile materials for blind people, such as manual and electronic braille writers, learning tools, adaptive paper
- Hearing aids
- Pencil grips

T4H complements MA state plan and waiver services. Since 2013, the T4H contractor has conducted over 20,000 assessment and training visits. Current funding allows T4H to see 300 new people each year. This number has decreased since inception as the cost of business has increased, but the grant amount has not increased since it was established by the legislature. There is a high demand for assistive technology services and the current grantee maintains a waiting list nearly six months long.

Authorized by the 2019 Legislature, the Technology First Task Force was created to advise DHS on strategies to increase the use of supportive technology for people with disabilities to enable them to live more independently, work in competitive integrated environments, participate in inclusive community activities, and increase quality of life. One of the recommendations from the task force's final report, was to eliminate the specialized equipment and supplies limit. Specialized equipment and supplies is a waiver service on the Brain Injury (BI), Community Alternative Care (CAC), or Community Access for Disability Inclusion (CADI) waivers. Specialized equipment and supplies has an annual limit of $3,909, whereas a similar service available to people on the Developmental Disabilities (DD) waiver has no limit. The specialized equipment and supplies limit is frequently insufficient to meet both a person's assistive technology needs as well as their specialized supplies needs.

Proposal:

First, this proposal would increase T4H grant funding by nearly 50%, allowing expanding access to approximately 150 more people every year. The current grant is funded at $621,000 annually and the grantee is required to provide assistive technology consultations for at least 315 unduplicated individuals in a contract year and provide at least 900 face-to-face assistive technology consultation assessments or follow-up visits to individuals each year.

Next, this proposal will broaden the purpose of the T4H grant. To qualify for this grant, a person needs to be receiving home care or home and community-based waiver services and either live in their own home or plan to live in their own home and need assistive technology to meet a safety, communication, community engagement or achieve higher independence goal. This proposal broadens the grant purpose to allow the grantee/grantees to work with people in residential settings who wish to reduce reliance on paid staff, in addition to working with roughly 150 more people per contract year.

Lastly, the proposal increases the Specialized Equipment and Supplies waiver service annual limit from $3,909 annually to $10,000 annually, to account for the growing list of assistive technology and specialized equipment that helps people increase or maintain independence and reduce reliance on formal caregivers.

Impact on Children and Families:

This proposal would more closely align the access to assistive technology for children and families on BI, CAC and CADI waivers with those on the DD waiver who are not subject to an annual limit on their technology needs. In addition, technology has been identified as a premiere solution to the workforce shortage issues as assistive technology allows people to do things for themselves that they would otherwise need staff or caregivers to do for them. Many therapeutic interventions for children involve or require the use of technology.

The earlier people become comfortable and confident using technology, the more independent they will be as they move into adulthood. The early use of technology can also help bridge the digital divide experienced by people with disabilities.

The Minnesota Department of Education (MDE) supports a variety of Assistive Technology initiatives designed to help ensure students with disabilities have access to appropriate assistive technology and receive a free, appropriate public education. These initiatives include professional development, information dissemination, and technical assistance. Educators must consider assistive technology for all children with an Individualized Education Program and provide this technology for students who require it. MDE Assistive Technology initiatives are identified in Minnesota's Olmstead Plan as strategies for increasing the number of students with disabilities receiving access to appropriate assistive technology.

Equity and Inclusion:

People who use the HCBS waivers also reflect Minnesota's wider diversity. In 2021, 32% percent of people on CAC, CADI, and BI waivers and about 19% of people on the DD waiver were people of color or American Indian. 55% of people in the Home Care program, who can be served by the Technology for Home grant, are black, indigenous and people of color.

No negative impacts have been identified with this proposal. Positive impacts would include additional purchasing ability, greater access to increased independence, increased access to the use of remote support, greater access to early therapeutic interventions, decreased reliance on staff and caregivers, and many more for all.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒ Yes
☐ No

Tribal governments may benefit from the Technology for Home Grants. Three tribes have lead agency contracts to provide waiver services: Red Lake, White Earth, and Leech Lake. These Tribal governments would benefit from an increase to the increase in Specialized Equipment and Supplies.

Impacts to Counties:

This proposal will have no direct impact to counties or lead agencies. However, this proposal is responsive to lead agency feedback. Lead agencies have provided positive feedback on the assessments delivered by grantees under the technology for home grant and requested the state consider raising the limits for specialized equipment and supplies.

IT Costs

Increasing the specialized equipment and supplies (SES) service limit from $3,909 to $10,000 requires updates to the Medicaid Management Information System (MMIS). Changes include service authorization adjustments, claim processing and edit programming to ensure the integrity of the waiver service requirements.

Results:

The Technology 4 Home grantee is responsible for meeting contract goals and deliverables. This includes follow up with people who receive their consultations

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Increase funding to allow Technology 4 Home contractors to see more people receiving home care or HCBS services	315 people/year	465+ people/year*	Funding available July 1, 2023
Quality	T4H grantees will attempt to balance their participants among all waiver and home care populations as well as reach out to each of the 87 counties and 11 tribe each year to seek referrals	Seek referrals from all 87 counties and 11 tribes	Seek referrals from all 87 counties and 11 tribes	ongoing
Results	90% of individuals receiving T4H consultation will still use any recommended AT after 6 months and 12 months	90%	90%	Ongoing

Performance data is tracked by the grantee. Follow up is conducted with participants and their lead agency workers.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
General Fund			352	405	757	405	405	810
HCAF								
Federal TANF								
Other Fund								
Total All Funds			352	405	757	405	405	810
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	55	Disabilities Grants	300	300	600	300	300	600
GF	33	CCB LW SES Cap Increase	43	103	146	103	103	206
GF	16	Systems	9	2	11	2	2	4
		Requested FTEs	0	**0**		**0**	**0**	
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

A new section in the statutory code is needed, as well as a rider.

Change Item Title: Life Sharing Benefit and Family Residential Rate Tiers

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	0	0	(320)	(6,127)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	(320)	(6,127)
FTEs	**0**	**0**	**0**	**0**

Recommendation:

Effective January 1, 2026, or upon federal approval, the governor recommends improving family residential service options available under Minnesota's disability waivers to address challenges in the direct care workforce and promote service delivery models that better meet the goals of people with disabilities. This proposal enhances the services available under the disability waivers by creating a discrete MA service for Life Sharing. It also implements rate tiers for Family Residential Services (FRS) that align with a person's assessed support needs.

The fiscal impact of this proposal results in a savings of $6.5 million in fiscal years 2026-27.

Rationale/Background:

In January 2014, the Minnesota Department of Human Services (DHS) implemented the Disability Waiver Rate System (DWRS). The DWRS transitioned the state from a variable, county-negotiated rate methodology to a standard, statewide methodology for most disability waiver services. Family Residential Services (FRS) are ongoing residential care and supportive services for people living in a home where the license holder also resides. FRS have a DWRS rate framework, but the service is unique among DWRS services. The FRS rate framework uses many of the same rate component values as corporate settings, even though these settings likely have different costs. The framework includes staffing hours, which are challenging to calculate for settings where the service provider lives in the home. Payments for this service are also tax exempt for most families who are providing support for people they live with. These challenges result in DWRS rates that do not align with a person's support needs. They also permit FRS services models which can be indistinguishable from corporate models that employ shift staff and rely on economies of scale, sometimes at the expense of individualized, person-centered care.

Over the years, advocates and providers have promoted more person-centered family residential models. "Life Sharing" is a service model that has been implemented in other states and informally in Minnesota. It is a relationship-based living arrangement that carefully matches an adult age 18 or older who has a disability with an individual or family who will share their life and experiences and support the person using person-centered practices. Life Sharing matching is a robust relationship-based coordination of matching personality characteristics of mutual parties who choose to live together. Life Sharing matching can currently be authorized using existing waiver services of family training and counseling. Different that family residential services (FRS), Life Sharing caps the amount of people that are served in one home from a maximum capacity of four to a maximum capacity of four.

The current methodology for calculating family residential services is based on a prospective, cost-based framework for corporate residential (corporate foster care/community residential services) providers. Reliance

on this methodology has resulted in rates that are inconsistent throughout the state and do not have a direct relationship to the actual day-to-day support needs of the person who receives the service.

The 2019 Legislature authorized the Blue-Ribbon Commission on Health and Human Services to develop an action plan "to advise and assist the legislature and governor in transforming the health and human services system to build greater efficiencies, savings, and better outcomes for Minnesotans." Specifically, the legislation charged the Commission to identify strategies in the final action plan that would enable the legislature to enact future legislation that would reduce health and human services expenditures by $100,000,000 for the biennium beginning July 1, 2021. The Commission met throughout 2019 and 2020 to solicit proposals from the community, analyze and organize strategies, and to gather feedback from community partners and stakeholders. Following this process, the Commission published a final report and submitted it to the Legislature. Creating a tiered rate standard for family residential services was ultimately recommended in the Family Foster Care Rate Methodology legislative report and included in the Blue-Ribbon Commission's report.

The workforce shortage has reached crisis levels in Minnesota, with job vacancies at record highs across all sectors. The hardest hit economic sectors are healthcare and social assistance, with 52,340 vacancies in the fourth quarter of 2021. [1] The number of Minnesotans turning 65 in this decade (about 285,000) will be greater than the past four decades combined. The total number of older adults (65+) is anticipated to double between 2010 and 2030.[2] By then, more than 1 in 5 Minnesotans will be an older adult. Compounding the sweeping workforce shifts, disability and conditions that necessitate the need for independent living supports become more prevalent as people age. While 9% of individuals between the ages of 18-64 have a disability, the percentage of individuals with a disability nearly quadruples to about 34% for people ages 65-84. [3] This proposal promotes innovative service models to mitigate impacts of the workforce crisis on people needing services.

Proposal:

This proposal establishes a formal Life Sharing MA benefit that promotes relationship-based services and adds specified matching services to promote family providers' access to coordinate and find people who choose to live with one another. In addition, and to support the development of Life Sharing, this proposal implements a tiered rate structure recommended in the Family Foster Care Rate Methodology legislative report. This change would be implemented beginning January 1, 2026, or upon federal approval, whichever is later.

The newly established Life Sharing service will use the new FRS rate tiers methodology. These tiers are based on a person's individual budget support range once individual budgets are implemented. The rates would be updated biennially to keep pace with inflation.

The FRS rate tiers are as follows:

Individual budget support range	Proposed rate
1	$154.82
2	$186.70
L	$201.89
3	$243.22
4	$243.22
H and E	$304.62

Providers that support the Life Sharing matching process would continue receiving funding under the existing family training and counseling service. A provider that supports the family/individual providing Life Sharing would use existing services listed in the life sharing matching and on-going support options guidance and adhere to the

appropriate rate structure tied to each unique service option. To incentivize the use of Life Sharing, the tiered rates are enhanced beyond those of FRS. The Life Sharing rate tiers are as follows:

Individual budget support range	Proposed rate
1	FRS rate + 10%
2	FRS rate + 10%
L	FRS rate + 10%
3	FRS rate + 10%
4	FRS rate + 10%
H and E	FRS rate + 10%

Impact on Children and Families:

Life Sharing is a family-centered support. Although minors are not eligible for the service, this proposal would advance family-centered service designs under Minnesota's Medical Assistance Disability Waiver system. Life Sharing will allow Minnesotans with disabilities to live in homes that have a family-like atmosphere rather than living in settings that are more akin to community residential services (CRS), sometimes referred to as "group homes." Not only does this arrangement better serve the person, it also expands and diversifies families, often bringing a sensing of completeness and joyousness to the home. In family homes where minor children reside, the addition of a person with a disability can help children to have more empathy and reduced anxiety. Research suggests that promoting interaction between developing children and people with disabilities has the potential to help reduce discrimination.

Equity and Inclusion:

This proposal will enhance and create more living arrangement opportunities for people with disabilities. Stakeholder groups have been consulted and represent people with disabilities, providers, and local lead agencies. This will increase options for people with disabilities to be included in their communities of choice based on person-centered best practices and using one-person at a time approaches. People with disabilities and potential life sharing providers will be solicited from a variety of groups/communities specific to: Racial and Ethnic groups, Lesbian, Gay, Bisexual and Transgender groups, Persons with Disabilities and Veterans.

DHS conducted an equity analysis to examine the racial breakdown of people who receive Family Residential Services and determined whether impact of the rate change differs based on people's race. This analysis included each person who received this service in fiscal year 2018 (n = 1,266). To examine utilization by race, DHS compared the percent of people receiving Family Residential Services by race to the population of people how receive long-term services and supports. To examine whether the rate change would affect people differently by race, DHS calculated the percent change from each person's 2018 rate to the proposed rate under the tiered structure. Then, the analysis used a regression model to test whether race predicted the percent change.

Race	Percent of people receiving FRS	Percent of people receiving LTSS
African American/Black	5.3%	16.6%
American Indian	3.5%	2.4%
Asian or Pacific Islander	1.7%	7.5%
Hispanic	1.6%	2.3%
White	84.9%	64.9%

Two or More Races	1.5%	1.0%
Unknown	1.5%	5.4%

Compared to the population of people who receive LTSS, proportionately more people who are white, American Indian, or two or more races received Family Residential Services. Proportionately fewer people who are African American or Black, Hispanic, Asian or Pacific Islander, or whose race was unknown received Family Residential Services. Thus, this would decrease rates and spending for a service that is more frequently used by people who are white, slightly more frequently used by people who are American Indian or two or more races, and less frequently used by people who are African American or Black, Hispanic, Asian or Pacific Islander, or whose race was not reported.

The model showed that race did not statistically significantly predict a positive or negative rate change, and that race accounted for 0% of the variance in the rate change. These results indicated that, among people who receive this service, this rate change would impact people equitably across racial groups.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

While this proposal does not have a direct impact on the operations of Tribal Nations, American Indian and Indigenous communities have historic practices and traditions that involve nuclear and extended family members in raising children. In addition, American Indian and Indigenous populations are less likely to choose institutional-like settings for their loved ones, preferring more familial and community-based options. Life Sharing will add a new, family-based option for these communities.

Impacts to Counties:

This proposal would give lead agencies and people receiving services an alternative service to congregate residential services. Additionally, the rate tiers created by this proposal for family residential services would provide a consistent rate methodology to lead agency case managers for these services.

IT Costs

These system changes are for MNCHOICES updates for implementation for Life Sharing rate tiers.

Category	***FY 2024***	***FY 2025***	***FY 2026***	***FY 2027***	***FY 2028***	***FY 2029***
Payroll						
Professional/Technical Contracts			25		25	
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)						

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Total						
MNIT FTEs						
Agency FTEs						

Results:

- There will be an annual increase in the enrollment of people who will provide Life Sharing to people who receive services and people who receive services.
- Between 1998 and 2016, the number of LTSS recipients with IDD living in a host/foster home or IDD group setting of three or fewer people increased 132% from 63,279 to 146,625 people according to national data.
- The Life Sharing Support Service will provide long-term quality monitoring of health, safety and programmatic outcomes.
- The rate of Behavior Intervention Reporting Form data will be examined over time to show reductions of conflicts/incidents of people supported in Life Sharing experiences who were carefully and intentional matched process using person-centered practices. Data from where they previously lived can be used to compare to the new living arrangement.
- People who receive services will experience a community life specific to the outcomes desired in their person-centered plans.
- Behavior Intervention Reporting Form data will decrease as people move to Life Sharing.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
General Fund			0	0	0	(320)	(6,127)	(6,447)
HCAF								
Federal TANF								
Other Fund								
Total All Funds			0	0	0	(320)	(6,127)	(6,447)
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	33	MA LW	0	0	0	(345)	(6,127)	(6,472)
GF	11	Systems	0	0	0	25	0	25
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

245D.03

Change Item Title: Improving Access to Behavioral Health Services

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	10,876	16,892	21,198	21,184
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	10,876	16,892	21,198	21,184
FTEs	**12**	**12**	**12**	**12**

Recommendation:

The Governor recommends investing $27.768 million in fiscal years 2024-25 and $42.382 million in fiscal years 2026-27 to improve access to residential and outpatient behavioral health services for children and adults.

This proposal does the following:

1) Provides ongoing, forecasted funding to cover room and board expenses for children who access children's residential facilities (CRF) services via non-child protection entry points;
2) Increases the rate for Adult Day Treatment (ADT) to ensure people have step-down options from acute treatment services;
3) Provides ongoing funding for the Transition to Community Initiative and expands eligibility to children;
4) Appropriates ongoing base funding for an online behavioral health program tool to expand capability and sustainability, ensuring people and families can find programs that meet their needs when they need them; and
5) Appropriates additional funding and administrative support for School-Linked Behavioral Health (SLBH) grants.

Rationale/Background:

It is estimated that 26 percent of the adult population and 40 percent of adolescents have experienced a mental illness within the past 12 months. According to the National Survey of Children's Health, 31 percent of children in Minnesota with a mental or behavioral health condition that needed treatment did not receive services. Of these children that did not receive needed services, 30 percent were uninsured at the time. Black, non-Hispanic children were most likely to report not receiving treatment when needed (55.5%). Among adolescents aged 12 to 17 living in Minnesota, 11 percent (47,000 adolescents) experienced a major depressive episode within the past year and only 54 percent of the adolescents experiencing mental health problems received mental health services.

Children's Residential Facilities (CRFs)

Children's residential facilities (CRF) are licensed under Minnesota Rules, chapter 2960 to provide temporary care or treatment to children in a group setting when not living with a parent or guardian. Services include supervision, food, lodging, training, education, and treatment.

The Children's Mental Health (CMH) Residential Services Path "third Path" is a new option for children with a severe emotional disturbance (SED) to access treatment at children's residential facilities (CRFs), outside of the

child welfare system. Accessing CRF treatment via the Third Path ensures that the services and treatment plan are family-driven while reducing the likelihood of the need for more intensive, restrictive, and cost prohibitive services. CMH Residential Services Path treatment services are designed to support children and their families in improving the child's functioning within the family, school, and community. The desired outcomes also include increasing the child's ability to gain and maintain positive social interaction skills while building resiliency.

The CMH Residential Services Path provides a child with a severe emotional disturbance (SED) and the child's family an additional way to gain access to a licensed children's residential facility (CRF). The CMH Residential Services Path is an optional path to access services, not a placement. The child and family do not sign a voluntary placement agreement. The parent or the child's legal representative selects the level of county or Initiative tribe's involvement when a child uses this path. The county or Initiative tribe does not receive Title IV-E reimbursement[1] while maintaining responsibility for payment of the costs of room and board using the CMH Residential Services Path state allocated funds. The 2021 Legislature required DHS to engage with stakeholders to identify alternative ways to fund room and board costs for children accessing CRFs via the CMH Residential Services Path. Stakeholders recommended the Behavioral Health Fund (BHF) as a sustainable funding source to pay for room and board costs for children accessing services in children's residential facilities (CRFs) via non child protection entry points.

Adult Day Treatment

Adult day treatment is a short-term, community-based mental health program consisting of group psychotherapy, rehabilitative interventions and other therapeutic group services provided by a multidisciplinary team under the clinical supervision of a mental health professional. The goal of Adult Day Treatment is to reduce or relieve the effects of symptoms associated with a diagnosed mental illness and provide skills training that will result an improved ability to live and function more independently in the community. The payment rate for Adult Day Treatment has not received an increase in many years and recent data shows that providers have experienced a decrease in both individuals served as well as a decrease in service units by individual, which the pandemic has likely had a large impact on.

Transition to Community Initiative

In 2021 the legislature appropriated over $16 million in one-time, temporary funding for FY 2022-2024 to fund activities to assist people in moving from facilities or provider-controlled settings to a home of their own. Transition to Community Initiative, initially established in 2013 as home and community-based services transitions grants, was developed to reduce the time that individuals remain at the Anoka Metro Regional Treatment Center (AMRTC) or the Forensic Mental Health Program (FMHP) when services are no longer clinically necessary. This help ensure that psychiatric beds at AMRTC and FMHP remain available for those who need them the most.

Transition to Community Initiative awards grants so that individuals are able to live in the least restrictive setting and as independently as possible, build or maintain relationships with family and friends, and participate in community life. Transition to Community Initiatives promotes access to customized, community and integrated settings through a combination of county grants and housing assistance. Grantees are required to use a person-centered planning process and informed choice decision making. The initiative provides access to a range of services, including home and community based (HCBS) waivers, flexible grant funding, intensive care coordination, and partnerships with providers and counties to address an individual's unique needs.

The 2021 funding expanded the Whatever It Takes (WIT) services to include the Community Mental Health Psychiatric Units around the state and the Community Behavioral Health Hospitals for patients who are on the FMHP or AMRTC waiting lists to divert them from having to be admitted to state hospital systems. Funding also assists people receiving disability waiver services who are living in provider-controlled settings, like corporate

[1] Children's Bureau, An Office of the Administration for Children and Families. Title IV-E

foster care and customized living, to move to a home of their own. All grant activities using the 2021 funding must be completed by March 31, 2024. Current grant activities are restricted to adult populations.

Online tool to find behavioral health treatment

Minnesota currently relies on an online search tool called FastTracker. This tool helps people and families locate outpatient and residential mental health and substance use disorder programs in Minnesota. FastTacker is currently funded through various onetime funding streams. With ongoing, sustained funding Minnesota could support FastTracker or another tool to enhance their capabilities, including notating when programs specialize in serving culturally-specific populations, services that serve specific needs, user data, and when they meet certain quality standards.

School-Linked Behavioral Health (SLBH) grants

Since 2007, Minnesota has pioneered efforts to bring behavioral health services to students through the school linked behavioral health program. Under Minnesota's model of school-linked behavioral health, community mental health agencies place mental health professionals and practitioners in partnering schools and school districts to provide direct behavioral health services to students. These services work to increase access to behavioral health services for all children, particularly children and youth who are uninsured and underinsured, to improve clinical and functional outcomes for children and youth with a behavioral health disorder and improve identification of behavioral health issues. These behavioral health providers also support parents, caregivers, consult with teachers, provide care coordination and deliver classroom presentations and school-wide trainings on behavioral health issues.

SLBH is a grant program and has grown dramatically in the last 5 years due to many mental health and educational advocates asking for more services for students, their families, and supports for the teaching staff. Outcomes for this program include 1) increased coordination of care, with services delivered to where the kids spend the majority of their time, school 2) increased access and sustained engagement in treatment and 3) increased evidence-based mental health services from trained mental health professionals regardless of their insurance status.

School-linked mental health grants were expanded to include intermediate school districts in 2018. Grants were awarded with the goal of improving clinical outcomes for students, helping students to return to their home school district, reversing the disproportionate impact on students of color, and providing support and training for school staff and parents.

Intermediate schools provide highly specialized educational programs to students and families, such as special education, area learning centers, career tech programs and online learning. Minnesota has four intermediate districts that serve more than 20,000 students annually.

Mental health problems are common, affecting one in every five young people. In Minnesota, nine percent of school-age children and five percent of preschool children have a serious emotional disturbance, which is a mental health problem that has become longer lasting and interferes significantly with the child's functioning at home and in school. An estimated 109,000 children and youth, birth to age 21, in Minnesota need treatment for serious emotional disturbances. With appropriate identification, evaluation, and treatment, children and adolescents living with mental illness can achieve success in family life, in school, and in work. However, the overwhelming majority of children with mental disorders fail to be identified and lack access to treatment and supports.

Proposal:

This proposal includes the following provisions:

(1) ***Amends statute to allow payment for room and board from the forecasted Behavioral Health Fund (BHF), for children accessing services in children's residential facilities (CRFs) via non child protection entry points.***

This provision will allow counties and Initiative tribes to bill room and board costs for children accessing CRF services through the non-child protection pathway, also known as the "third path." Room and board payments would be billed using the adolescent residential treatment per diem rate of $75.29. The previously appropriated county and Tribal government CRF room and board allocations of $1.979 million will be cancelled starting in FY 2025, offsetting the forecasted investment through the Behavioral Health Fund. This cancellation won't occur until the new methodology is fully implemented. The funding will also include one FTE in the Operations division to assist with ensuring this program works effectively.

(2) Invests $2.358 million from FY 24-FY 27 to increase the payment rate for Adult Day Treatment by 50% effective January 1, 2024

This provision invests $2.358 million from FY 24-FY 27 to increase the payment rate for Adult Day Treatment by 50% effective January 1, 2024. Adult day treatment services are intended to stabilize an individual's mental health status and develop and improve an individual's independent living and socialization skills. A rate increase for this service will help ensure that providers are able to continue serving individuals with a diagnosed mental illness so that they are able to receive the support they need to live in the community.

Adult day treatment is an important component of the mental health services continuum and assists individuals in building and maintaining independence. It strives to allow a person to live to their full potential while also preventing a need for a higher level of care. Individuals in Adult Day Treatment must have an individual treatment plan that is a collaborative and person-centered process involving the individual, and with the permission of the individual, the individual's family and others in the individual's support system. Several adult day treatment programs have closed over the past year and many others are on the brink of closure.

(3) Invests $1,720,000 to RFP for an online behavioral health program locator

This provision provides ongoing funding to issue an RFP for an online behavioral health program locator tool with enhanced functionality than currently exists. For example, the RFP will require that the awarded vendor include designations and information about programs that serve culturally specific or other targeted populations. It will also allow continued expansion of the provider database allowing people to research and access mental health and substance use disorder treatment options. The RFP will be awarded in FY2024 with an annual, ongoing cost of $1,720,000.

(4) Invests $15.96 million in FY2024-25 and $26.548 million in FY2026-27 to increase funding for School Linked Behavioral Health grants and Intermediate school-linked behavioral grants.

Increasing school-linked behavioral health grant funding will support the behavioral health needs of children, youth, and families as they weather and emerge from the pandemic. The funds will be distributed to school-linked behavioral health providers in order to sustain current school services and increase capacity to partner with additional school districts. TThis investment would serve approximately 8,100 students who are in need of behavioral health services in more than 1,100 school sites across Minnesota. Teachers in more than 1,100 school sites will have access to consultations with behavioral health professionals to process their struggles as they serve students with behavioral health needs. School-linked behavioral health staff will also partner with specialized instructional support personnel to support school wide efforts to mitigate the behavioral health impact on teachers and students.

The grants will add dollars and deliverables to current contracts for school-linked behavioral health providers as well as for the intermediate school district contracts, and SLBH Tribal partners . The Department of Human Services (DHS) will amend the current contracts to provide the following services to children and families:

- Provide mental health and chemical health treatment to children.
- Provide support to families through family therapy, family education, peer support and connection with experienced parents.
- Services to meet the needs for children and families from Black, Indigenous, and People of Color (BIPOC) communities.

In addition, this proposal addresses the vulnerability of educational staff to experience stress and vicarious trauma during this post-pandemic teaching time. $1 million of this proposal is designated for school staff to create spaces for teachers and other school staff to seek support. DHS will provide technical assistance support in collaboration with the Minnesota Department of Education (MDE). Funding will be administered through amendment of current contracts with school-linked behavioral health providers through DHS. An annual appropriation of $624,112 would be reserved for four (4) positions at DHS for administration. Three (3) positions to assist with data management and reporting, and one fiscal position to assist with general accounting and auditing requirements.

(5) Transition to Community- Invests $10.442 million in FY 24-25 and $16.174 million in FY 26-27

This proposal invests $8.375 million in grants to expand eligibility to children and to increase the base funding for Transition to Community Initiative from FY 24 -25. This increase will extend, on a permanent basis, the temporary increase approved by the 2021 legislature and provide ongoing funding for staffing.

The funding assists people to exit Anoka-Metro Regional Treatment Center (AMRTC), community mental health psychiatric units, and Community Behavioral Health Hospitals (CBHHs) as well as people who are on the Forensic Mental Health Program (FMHP) or AMRTC waiting lists. Transition to Community Initiatives also assists people receiving disability waiver services who are living in provider-controlled settings, like corporate foster care and customized living, to move to a home of their own.

The original grant appropriation from the 2021 legislative session for transition grants for the Transition to Community initiative was $4 million per year under the Adult Mental Health budget activity. In addition, $2 million was appropriated per year under the Disability grants budget activity for people with disabilities. This proposal makes that grant funding permanent starting in FY 2024. Also, the investment adds $500,000 in FY 24 and another $1 million per year starting in FY 2025 to include children as eligible recipients of these grants. In addition, the administrative funding is made permanent as well starting in FY 2024. Six FTEs were originally appropriated with the original funding. One additional FTE is requested for a Community Forensic navigator.

Impact on Children and Families:

School-Linked Behavioral Health services have proven particularly effective in reaching children who have never accessed mental health services. Many children with serious mental health needs are first identified through this program. Community mental health agencies provide mental health professionals and practitioners at schools, with most of their time involved in direct child and family services including assessment and treatment, as well as teacher consultation, care coordination and school-wide trainings.

Reports from the 2018 National Association of Elementary School Principals: a 10 Year Study; showed the top four ranking areas characterized as an extreme or high concern for their schools were as follows:

- Increase in the number of students with emotional problems – 73.7%
- Student mental health issues – 65.5%
- Students not performing to their level of potential – 62.3%
- Providing a continuum of services for students who are at risk – 61.6%

Minnesota released the results of the 2019 Minnesota Student Survey (MSS), showing that:

- Fewer students feel engaged in school, believe their school provides a supportive place for learning, report good health, or feel safe.
- More Minnesota students than ever report having long-term mental health, behavioral or emotional problems. This number is up from 18 percent of students surveyed in 2016 to 23 percent in 2019.
- Eleventh-grade female students who report having long-term mental health, behavioral or emotional problems has more than doubled from 2013 to 2019.
- 11th-grade female students who reported missing a full or partial day of school in the last 30 days, 24 percent reported that they missed school because they felt very sad, hopeless, anxious, stressed or angry.
- Suicide Ideation: Reports of suicide ideation increased for all grade levels in the last six years. In 2013, 20 percent of 11th-grade students reported seriously considering suicide at some point in their lives, compared to 24 percent of 11th-graders in 2019.

The Minnesota Safe Learning Survey final summary report (February 2022), concluded that mental health is a serious concern for educators, families, and students. Survey responds consistently ranked mental health as a top-ranking challenge according to 2021 data collected in the winter, spring, and fall. Mental health has been an ongoing concern, likely made worse by the pandemic.

This proposal is a key component of the administration's priority that all children have access to mental health supports. Families and Tribal Nations were a part of Preschool Development Grant engagement. Three Tribal Nations currently have Mental Health Consultation available. This work builds on successful existing work and is a proven intervention to reduce the educational disparities experienced by children of color.

Preventing suspension and expulsion is a key goal of the Minnesota Department of Education. The proposal supports preventative services. Minnesota spent over $5 million in 2016 providing intensive mental health services to 68 young children who were expelled from childcare. Mental health consultation could have prevented the expulsion of those children from childcare, prevented their need for day treatment, and served an additional 900-1,200 children at a fifth of the cost.

Equity and Inclusion:

Nearly one in five children in the United States live in poverty, and youth from lower income households are less likely to access health care and more likely to experience significant mental health symptoms, such as suicidality among boys. Youth experiencing food insecurity or homelessness are at higher risk of mental health concerns. Mental health condition and symptom severity differs based on race and ethnicity. Black teens have disproportionately higher rates of suicide than White teens, and the odds of having attempted suicide within the past year were significantly greater among Asian international and Black college students than in previous years. There are also racial and ethnic in terms of the extent to which individuals seek, access, and use mental health services. Unmet mental health needs may manifest in behaviors inconsistent with school or program expectations and students of color who exhibit these behaviors are more likely to experience reactive and exclusionary discipline rather than interventions or additional supports and lose instructional time. Based on these experiences, children and youth of color often have poorer outcomes than white peers. Racism, not race, is a critical risk factor for mental health concerns and poorer outcomes. For example, darker-skinned Latino children may be at increased risk for more severe and/or more persistent mental health problems, than fairer-skinned Latino children perhaps due to discrimination based on their skin color (Calzada et al., 2019). There is also evidence that ethnicity can be a significant positive predictor of mental health, whereas racial status, stress, and impostor feelings were negative predictors for Black college students.

The school-linked behavioral health program has been adjusted in recent years to support an expansion of culturally and linguistically diverse services and providers. This includes an agency contracting with state academies for hard of hearing and blind/visually impaired students and allowing "practice groups" of providers to

become eligible grantees in order to encourage small, culturally specific providers access to the program to support students in their communities.

Supporting counties to allow people to access CRF services through a non-child protection option could have a positive impact on equity by providing families from communities that are distrustful of entering the child protection system, an option that does not involve court or other child protection related proceedings. The ability to obtain mental health care and disability services for their children outside of the foster care system may encourage more American Indian, African American, and other families of color to seek the care their children need, which may in turn result in better long-term outcomes.

Adult Black, Indigenous, and People of Color populations also experience disparities in mental health outcomes and access to clinical and culturally responsive care. Native/Indigenous people in America report experiencing serious psychological distress 2.5 times more than the general population over a month's time. Although overall suicide rates are similar to those of whites, there are significant differences among certain age groups. The suicide death rate for Native/Indigenous people in America between the ages of 15-19 is more than double that of non-Hispanic whites. Native/Indigenous people in America start to use and abuse alcohol and other drugs at younger ages, and at higher rates, than all other ethnic groups. Access to mental health services is severely limited by the rural, isolated location of many Native/Indigenous communities. Additionally, access is limited because most clinics and hospitals of the Indian Health Service are located on reservations, yet the majority of Native/Indigenous people in America live outside of tribal areas. Compared to non-Hispanic whites, nearly 3 times as many Native/Indigenous people had no health insurance – 5.9 percent compared to 14.9 percent. Approximately 43 percent of Native/Indigenous people in America rely on the Medicaid or public coverage.

The COVID-19 pandemic and the murder of George Floyd has highlighted racial and ethnic disparities in access to behavioral health care. Blacks and Latinos have substantially lower access to mental health and substance-use treatment services than other populations. They are also more likely to terminate treatment prematurely and they experience less culturally responsive care. Blacks and Latinos with mental health and substance use disorders are more likely to be incarcerated and homeless than the general population, putting them at increased risk of decompensation of behavioral and physical health conditions.

Lastly, research has found that mental health consultation results in a reduction in educational disparities experienced by children of color. Research shows that both teachers of color and white teachers worry about the behavior of African American boys more than African American girls, white girls or white boys.[i] Mental Health Consultation is implemented in a way that centers racial inequity in foundational trainings and provides tools to reduce racialized trauma. Trainings included as a part of consultation are Trauma, Stress and Healing 101, Racialized Trauma, Infants and Toddlers, and Secondary Trauma. As a results, research also shows that Mental Health Consultation can decrease or eliminate educational disparities.[ii] This work has led to the reduction in suspension and expulsion in childcare, which we assume would also be evident in school settings and address racial disparities.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Red Lake Nation, Leech Lake Band of Ojibwe, and the White Earth Nation may be positively impacted by room and board payments for CRF third path. Ongoing discussions with Tribal Nations are needed.

Impacts to Counties:
Counties have requested the room and board change and are expected to be positively impacted.

IT Costs

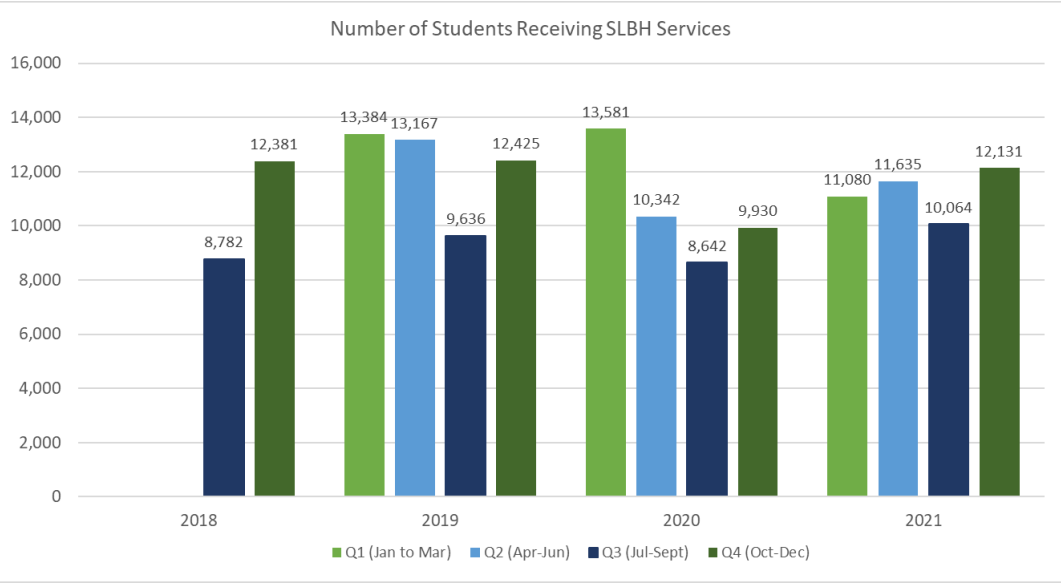
Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll						
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)	31,650	6,330	6,330	6,330	6,330	6,330
Total						
MNIT FTEs	2.75					
Agency FTEs						

System changes are estimated to require 211 hours of work and take approximately 3 months to complete with a total initial development cost of $31,650. Work is required to the MPSE system. System work is estimated to start on 9/1/2023 and be implemented on 1/1/2024.

Results:

- Increased access to and utilization of adult day treatment;
- Increase in the number of clinicians available to provide behavioral health treatment in a school setting
- Increase in the number of students of cultural minority groups receiving behavioral health services through the grant
- Improve early identification and interventions of behavioral health issues in elementary and middle school settings
- Improve system coordination and access for students who have been expelled or suspended from school

DHS tracks SLBH utilization and breadth of reach. See table below for number of students served by SLBH grants.



Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			10,876	16,892	27,768	21,198	21,184	42,382
HCAF								
Federal TANF								
Other Fund								
Total All Funds			10,876	16,892	27,768	21,198	21,184	42,382
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	35	CRF – Children's Residential Facilities- 3rd path	351	350	701	386	354	740
GF	58	Eliminate Children's residential grants- 3rd path	0	-1,979	-1,979	-1,979	-1,979	-3,958
GF	11	3rd Path - 1 FTE (OPS)	133	153	286	153	153	306
GF	33	MA State Cost Basic FFS – Adult Day treatment rates	108	282	390	282	280	562
GF	33	MA State Cost Fam w Ch/Eld & Disa MC – Adult Day Treatment rates	138	348	486	366	383	749
GF	33	MA State cost Adult MC – Adult Day Treatment rates	19	48	67	50	53	103
GF	15	Online BH Program Locator - Contract	1,720	1,720	3,440	1,720	1,720	3,440
GF	58	School Linked Behavioral Health (SLBH) Grants	2000	4,000	6,000	8,250	8,250	16,500
GF	58	Intermediate SLBH Grants	4,400	4,400	8,800	4,400	4,400	8,800
GF	11	SLBH – 2 FTEs (OPS)	265	306	571	306	306	612
GF	15	SLBH – 2 FTEs (BHDH)	274	318	592	318	318	636
GF	57	Whatever it Takes (WIT) Grants – Adult MH Grants	1,375	5,000	6,375	5,000	5,000	10,000
GF	55	WIT Grants – Disability Grants	500	2,000	2,500	2,000	2,000	4,000
GF	15	WIT – 7 FTEs (BHDH)	480	1,087	1,567	1,087	1,087	2,174
GF	11	MPSE Systems Costs	32	6	38	6	6	12
GF	REV1	FFP @ 32%	(919)	(1,147)	(2,066)	(1,147)	(1,147)	(2,294)
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
			12	12		12	12	

Statutory Change(s):

254B, session law

[i] Gilliam, WS., Maupin, AN, Reyes, C.R., Accavitti, M., Shick, F., 2016

[ii] Shivers, E. M., Guimond, A., Steier, A, 2015

Change Item Title: Mental Health Crisis and Early Intervention Service Expansion for Adults and Children

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	10,343	14,457	14,457	14,457
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	10,343	14,457	14,457	14,457
FTEs	**7**	**7**	**7**	**7**

Recommendation:

The Governor proposes to invest $24.8 million in the FY2024-2025 biennium and $28.914 million in the FY2026-2027 biennium to address widening gaps in the mental health continuum for children and adolescents and to improve the mental health and wellbeing of Minnesotans in every corner of the state.

This is a multifaceted proposal that includes the following components:

1) Expanding First Episode Psychosis (FEP);
2) Developing an Emerging Mood Disorders Program;
3) Investing in the Mobile Response and Stabilization Services (MRSS) model to provide front-line responders to support youth experiencing mental or behavioral health challenges;
4) Continued grant funding for mobile crisis teams;
5) Funding for tribally-based Mobile Crisis Response teams operating in Minnesota; and
6) Expansion of the Infant and Early Childhood Mental Health Consultation program to include schools.

Rationale/Background:

Prior to the pandemic, the need for children's mental health services was increasing. The pandemic has made the situation worse, exacerbating behavioral health needs among school-age children[1]. The full impact of the COVID-19 pandemic has yet to be determined, but we know that this has been a traumatic time for many people, especially children and adolescents. Children have experienced disruptions to activities that support healthy development and have been subjected to social isolation, traumatic grief, and loss of routines. The behavioral health and wellbeing of teenagers– a group that is historically difficult to engage in care—has also been impacted by the pandemic. Depression, suicide, eating disorders, and anxiety are on the rise and hospitals are reporting increases in emergency department visits and stays for children and adolescents experiencing behavioral health crises. Suicide remains the second leading cause of death among young people ages 10-24[2].

[1] https://aspe.hhs.gov/reports/child-adolescent-mental-health-during-covid-19
[2] https://www.cdc.gov/suicide/facts/index.html

Expanding First Episode Psychosis (FEP) and Developing an Emerging Mood Disorders Program

"Psychosis" describes conditions that affect the mind when there has been some loss of contact with reality. Psychosis can include hallucinations, paranoia, delusions, and disordered thoughts and speech, and can affect people from all walks of life. Psychosis often begins when a person is in their late teens to mid-twenties. Three out of 100 people will experience psychosis at some time in their lives, and about 100,000 adolescents and young adults in the US experience first episode psychosis each year.

Yet, studies have shown that it is common for a person to have psychotic symptoms for more than a year before receiving treatment. First Episode Psychosis (FEP) programs serve people 15 to 40 years old with early signs of psychosis. In Minnesota, there are currently four FEP programs, with capacity to serve 171 individuals.

In addition to psychosis, mood disorders can severely impact the quality of life for young adults who struggle with these types of diagnoses. Major depression and bipolar disorder are two types of mood disorders. While there are not yet evidence-based practices for treating mood disorders, there are some evidence-informed interventions. DHS is currently using federal mental health block grant dollars to contract with a provider to perform research and identify treatment options for emerging mood disorders, including a curriculum for the creation of an emerging mood disorder program. Just like for psychosis, early treatment of mood disorders, including major depression and bipolar disorder is critical. Early identification and treatment increase the chance of a successful recovery. First episode psychosis services are proven effective. (Source: Minnesota Results First, https://mn.gov/mmb/results-first/inventory/)

Expanding Mobile Crisis Grants

Mobile crisis services teams consist of mental health professionals and practitioners who provide psychiatric services to individuals, both adults and children, within their own homes and at other community sites outside the traditional clinical setting. These services are available across the state 24 hours a day, 7 days a week. Mobile crisis services provide for a rapid response and individual assessment, resolve crisis situations, and link individuals to needed services. Research has shown that mobile crisis services are:

- Effective at diverting people in crisis from psychiatric hospitalization;
- Effective at linking suicidal individuals discharged from the emergency department to services;
- Better than hospitalization at linking people in crisis to outpatient services; and
- Effective in finding hard-to-reach individuals.

In 2021 the legislature appropriated $20 million in one-time, temporary increases for FY 2022-2024 to strengthen the state's mobile crisis infrastructure to support counties and tribes to staff 24-hour mobile crisis lines and increase capacity to take more calls. The funding requires all grant activities to be completed by March 31, 2024 and provides for a June 30, 2024 expiration date. Mobile crisis services are proven effective. (Source: Minnesota Results First, https://mn.gov/mmb/results-first/inventory/)

Infant and Early Childhood Mental Health Consultation

Prior to the pandemic, the state conducted significant community engagement through its Preschool Development Grant with families, schools, Head Start, counties and more. A major finding was the need for mental health support and trauma-informed care for children and families. We also heard of concerns in the early childhood workforce of needing additional support to be trauma-informed, which led to overall recruitment and retention challenges. The pandemic exacerbated these challenges. Mental Health Consultation is a key preventative measure that can both meet community needs as well as the state's goals of building the necessary supports for students around mental health and social and emotional learning in a prevention setting.

Mental Health Consultation is a prevention service focused on building the adults' capacity to support children's emotional development and decrease mental health challenges. Mental Health Consultation includes a combination of training, reflective consultation (active listening, the exploration of the teacher's attitudes and beliefs about the situation, and problem solving) and skill building to support teachers, paraprofessionals, counselors/social workers and administrators so they may support the social emotional development of young children. This prevention service is a promising practice. (Source: Minnesota Results First, https://mn.gov/mmb/results-first/inventory/).

Proposal:

This is a multifaceted proposal that includes the following components:

- Expand the current First Episode Psychosis (FEP) program to increase service capacity, expand geographic availability, and develop new treatment teams in order to serve increased numbers of young adults experiencing the debilitating effects of psychosis
- Establishes an Emerging Mood Disorders Grant to conduct outreach and training, and creating new treatment teams focused on evidence-informed best practices for supporting young adults struggling with developing mood disorders.
- Pilot the Mobile Response and Stabilization Services (MRSS) model in Minnesota
- Continues the Mobile Crisis grants that were originally appropriated in the 2021 legislative session. The funding currently ends March 31, 2024 and enhances support for the state's Crisis Response System to coordinate with the 988 Suicide Prevention Line implementation.
- Adds funding for tribally-based Mobile Crisis Response teams operating in Minnesota including Red Lake Comprehensive Health, Red Lake Ombimindwaa, Leech Lake Nation and Fond du Lac.
- Expands the Infant and Early Childhood Mental Health Consultation program to include schools.

1. Expanding First Episode Psychosis (FEP)

This proposal increases funding by $1.35M per year starting in FY 2024 to expand access to First Episode Psychosis (FEP) teams to help ensure the availability of services to young adults and their families. Grant funds will be used to expand access to current FEP programs or add another FEP program. FEP programs provided support to individuals through a multidisciplinary team including family education/support, resiliency trainer, prescriber, case manager, peer support specialists, vocational rehabilitation work, and individual and family therapists.

2. Developing an Emerging Mood Disorders Program

The proposal also requests $1.25M million and 1 FTE starting in FY 2024 to fund the Emerging Mood Disorder program that uses evidence-informed interventions for youth and young adults who are at higher risk of developing a mood disorder or are already experiencing an emerging mood disorder such as major depression or bipolar disorder. Provide intensive treatment and support to adolescents and young adults experiencing or at risk of experiencing an emerging mood disorder. Intensive treatment and support includes medication management, psychoeducation for the individual and the individual's family, case management, employment support, education support, cognitive behavioral approaches, social skills training, peer support, crisis planning, and stress management;

- Conduct outreach and provide training and guidance to behavioral and health care professionals, including postsecondary health clinics, on early symptoms of mood disorders, screening tools, and best practices; and
- Ensure access for individuals to emerging mood disorder services, including ensuring access to services for individuals who live in rural areas.

Grant funding may be used to evaluate the efficacy for providing intensive services and supports to people with emerging mood disorders. Grant funding may also be used to pay for housing or travel expenses for individuals or to address other barriers preventing individuals and their families from participating in emerging mood disorder services.

3. Mobile Response and Stabilization Services (MRSS)

This proposal invests $1,000,000 in grants for up to four (4) qualified providers to implement the Mobile Response and Stabilization Services (MRSS) model starting in FY 2024. This proposal also invests $80,000 in FY 2024 to contract with a qualified contractor from the Institute for Innovation and Implementation at the University of Maryland's School of Social Work for technical assistance and training on MRSS to the State of Minnesota's Behavioral Health Division, first four (4) implementers and Mobile Crisis teams. In addition, the proposal includes one FTE starting in FY 2024 to develop the grant program, issue the RFP and grants and provide grant monitoring.

MRSS is a model which has quickly gained traction across the country to meet the growing mental health crisis needs of children, youth and families. New Jersey, Ohio, Oklahoma and even Hennepin County have implemented MRSS. Some states have added the model to their state plan, increasing capacity for federal funding investments. Hennepin County has shown positive outcomes for community-based providers implementing culturally specific MRSS to youth and families from the African American, Somali/East African, and Latinx communities.

The goal of MRSS is to promote access to crisis response services, reduce admissions to psychiatric hospitalizations and out-of-home placement services which are expensive and traumatic for children, youth and families. The model incorporates a two-pronged approach, providing an immediate, in-person response (within 60 minutes) to crisis as well as extended, longer-term (8 weeks) supports for the caregiver(s) and/or parent(s). This model helps families respond to their child's behavioral health crisis while bolstering the family's resilience and recovery.

The Behavioral Health Division's Mobile Crisis Team will implement MRSS in a four-year phased demonstration. The Qualified Contractor from the Institute for Innovation and Implementation at the University of Maryland's School of Social Work will facilitate a learning collaborative to ensure fidelity to the model; assist in the formulation of measurable outcomes and work with lead staff to explore and position the State of Minnesota to submit a state plan amendment and scale the model statewide.

- **Year 1**: Hire lead staff to facilitate tribal consultation and host stakeholder engagement sessions.
- **Year 2**: Publish Request for Proposal (RFP) and contract for up to four (4) qualified providers to demonstrate MRSS in Minnesota. Develop a learning collaborative to guide first implementers in the model and inform the state's MRSS policy and service design.
- **Years 3-4**: First implementers complete demonstration. Preparation to scale MRSS statewide pending desirable outcome measures.

National MRSS outcomes include:

- Proven cost-effective method for improving behavioral health outcomes;
- Reducing/deterring emergency department visits and inpatient admissions;
- Reducing referrals to child protective services;
- Reducing out-of-home placements;
- Reducing lengths of stay and the cost of inpatient hospitalizations; and
- Improving access to behavioral health services.

4. Expanding Mobile Crisis Grants

This proposal invests $12 million in FY 24-25 to increase the base funding for adult and children's mobile crisis services effective July 2023. This increase would extend, on a permanent basis, the temporary increase approved by the 2021 legislature and provide ongoing funding for staffing. This funding will permanently strengthen the state's mobile crisis infrastructure and help improve access to crisis services by supporting counties and tribes to staff 24-hour mobile crisis lines and increasing capacity to take more calls. While mobile crisis team provide a Medicaid billable service, grant dollars fund underinsured and uninsured individuals, as well as critical infrastructure costs and additional ancillary services and expenses that are not Medicaid billable.

The original grant appropriation for Mobile crisis grants under the Home and Community Based (HCBS) FMAP funding from the 2021 legislative session was $8,000,000 per year. This funding ends April 2024. This proposal makes that grant funding permanent starting in FY 2024 with $4,000,000 in FY 2024 ($4,000,000 was appropriated through HCBS FMAP funding for FY 2024) and $8,000,000 in FY 2025 and ongoing. This would also invest $1,000,000 in FY 2024 and ongoing for grants to tribally-based Mobile Crisis Response teams operating in Minnesota. In addition, the administrative funding is made permanent as well starting in FY 2024. Two MAPE 14L FTEs are included for the additional grant contract management.

Secondly, this proposal requests $150,000 starting in FY 2024 to increase grants to Mobile Crisis Response teams to support call triage, response and volume based on the 988 National Suicide Prevention Lifeline rollout. Calls are referred and routed to mobile crisis teams across the state of Minnesota from four (4) Lifeline Centers. As a result of increased call volume and referrals to Mobile Crisis providers across the state and, rural Minnesota, this proposal seeks investments for real-time GPS enabled technology compatible with 988 & 911 dispatch.

5. Tribal Mobile Crisis Response teams for Red Lake Comprehensive Health, Red Lake Ombimindwaa, Leech Lake Nation, and Fond du Lac

This proposal invests $1,000,000 in grants starting in FY 2024 to tribally-based Mobile Crisis Response teams operating in Minnesota including: Red Lake Comprehensive Health, Red Lake Ombimindwaa, Leech Lake Nation and Fond du Lac. Following completion of tribal consultation with each of these Nation's Mobile Crisis teams, funding will be distributed evenly to each tribally-based Mobile Crisis team and based on the results of consultation. Funding may be used to: 1) build upon and expand what's working well, 2) scale teams and add staffing to better meet gaps and needs, 3) cover costs of uninsured and underinsured service recipients and relatives, 4) develop awareness and communication campaigns including advertising and billboards which have proven effective to promote resources on reservations, 5) design cultural and traditionally-based mobile crisis programming to reduce out-of-home placements and divert psychiatric hospitalizations, 6) implement MRSS.

6. Infant and Early Childhood Mental Health Consultation

Effective July 1, 2023, this provision would expand an existing program at the Department of Human Services to include schools. Currently, Mental Health Consultation is available in all 87 counties and within three tribal nations. Mental health professionals are under contract with the State of Minnesota with expertise in young children's development and early childhood services provide the service. The funds requested are to offer a new service to schools. Funds will go towards expansion of the scope of work of the existing contracts at the Department of Human Services. This includes $1,000,000 in grants per year comprised of the following:

- Consultation to 100 sites per year at 50 hours per site ($750,000)
- Training and supervision of 25 consultants at 50 hours each ($125,000)
- Training by Supervisors at 250 hours ($50,000)
- Travel and supplies ($25,000)
- Evaluation ($50,000)

In addition, 2.0 FTE's are needed to manage this work in the Behavioral Health, Housing and Deaf and Hard of Hearing Administration at DHS (annual cost of $322,000). This includes 1 FTE (MAPE 14L) to support the grant management of this program and another FTE (MAPE 15L) to support the general administration of this program for contract and budget management.

Overall, this proposal includes one FTE in the Operations division to cover contract and accounting related administration for all grants included in this proposal.

Impact on Children and Families:

This proposal is expected to positively impact children and families and increase stability for children and youth to remain in their homes and schools. Additional positive outcomes include reduced need for psychiatric hospitalization, reduced need for child protective services reporting, and increased long-term ability to cope and stabilization in the home by both the children and their family members. Other states that have implemented this model report 79% of children who used the service were diverted from out-of-home placement and 90% of children who utilized this model while they were in school were able to successfully return to class.

Psychosis often begins when people are in their late teens to mid-twenties. First mood disorders occur before age 14 in about one-third of individuals, age 18 in almost half, and before age 25 in about 62% of the population. Early intervention for psychosis and mood disorders is key in improving outcomes for youth and young adults. Treating psychosis as early as possible after symptoms have appeared is important because research indicates that a shorter duration of untreated psychosis is associated with a better response to treatment and increases the likelihood of a good recovery. A prolonged delay in getting treatment may result in poorer symptomatic and functional recovery. The first five years after onset appears to be a critical period in which the symptoms are more responsive to treatment. In addition, if left untreated for a long time, psychosis can impact many areas of a person's life. Additional issues can arise such as social isolation, substance abuse or involvement with the criminal justice system, depression or other mental health problems, and suicide. Early intervention seeks to minimize the development of these additional problems and improve outcomes.

According to the Minnesota Out-of-Home Care and Permanency Report[3], American Indian children were 16.8 times more likely, African American/Black children more than 2.6 times more likely, and those identified as two or more races were 5.8 times more likely than white children to experience out of home placement, based on Minnesota population estimates from 2018.

This proposal is designed to have a positive impact on the numbers of children of color who are placed in out-of-home settings since children of color are removed from family homes at a disproportionate rate. Providing early, intensive supportive mental health services to families will reduce the number of children needing to be removed from their family home and will support ongoing skill building so parents can learn how to successfully manage their child's issues in the family home.

Equity and Inclusion:

Black/African Americans and Native Americans are overrepresented in the mental health and substance use disorder treatment system. Any increase in access to treatment and funding for related activities is anticipated to have a greater effect on these groups. Additionally, allowing funding to be used for housing or travel or other barriers would allow for individuals living in rural areas to access services that may not be in their geographic location without additional cost burdens.

This proposal would offer particular benefit to Black, Indigenous, and Communities of Color. According to the Minnesota Out-of-Home Care and Permanency Report[4], American Indian children were 16.8 times more likely, African American/Black children more than 2.6 times more likely, and those identified as two or more races were 5.8 times more likely than white children to experience out of home placement, based on Minnesota population estimates from 2018.

[3] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5408LA-ENG
[4] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5408LA-ENG

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Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

DHS consulted with Tribal Nations to prioritize and design funding for Tribal Mobile Crisis Response teams for Red Lake Comprehensive Health, Red Lake Ombimindwaa, Leech Lake Nation, and Fond du Lac under this proposal.

Impacts to Counties:

Counties are eligible to receive mobile crisis grant funding and would benefit from this provision. In addition, counties are eligible to respond to the Mobile Response and Stabilization Service Pilot.

IT Costs

There are no systems impacts in this proposal.

Results:

Expanding First Episode Psychosis (FEP) and Developing an Emerging Mood Disorders Program

- DHS contracts with the University of Minnesota, Twin Cities to perform research and identify treatment outcomes for emerging mood disorders, including a curriculum for the creation of an emerging mood disorder program.
- FEP programs are proven effective according to peer reviewed studies and confirmed by Minnesota Management and Budget Results First.

Expanding Mobile Crisis for Children, Youth, and Families:

- MRSS has the potential for a variety of positive results for youth and their families. The potential results include increased stability for children and youth to remain within their home and school. Additional positive outcomes can include reduced need for psychiatric hospitalization, reduced need for child protective services reporting, and increased long-term ability to cope and stabilization in the home by both the children and their family members. Other states that have implemented this model report 79% of children who used the service were diverted from out-of-home placement and 90% of children who utilized this model while they were in school were able to successfully return to class.[5]
- Mobile crisis services are evidence-based for adults, however we are not aware of research to confirm the same for children's mobile crisis. Nevertheless, we expect that increased funding for adult and child mobile crisis services will result in less hospitalizations and costly service authorizations, as well as improved outcomes for both children and adults.

[5] https://oklahoma.gov/content/dam/ok/en/odmhsas/documents/research/reports/Oklahoma-Youth-Crisis-Mobile-Response.pdf

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			10,343	14,457	24,800	14,457	14,457	28,914
Health Care Access Fund								
Federal fund								
Other fund								
Total All Funds			10,343	14,457	24,800	14,457	14,457	28,914
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	15	BHDH Admin – Emerging Mood 1 FTE	141	165	306	165	165	306
GF	58	Emerging Mood Grants	1,250	1,250	2,500	1,250	1,250	2,500
GF	58	MRSS - Grants	1,000	1,000	2,000	1,000	1,000	2,000
GF	15	MRSS - Contracts	80	0	80	0	0	0
GF	59	FEP - Grants	1,350	1,350	2,700	1,350	1,350	2,700
GF	15	BHDH – MRSS 1 FTE	141	165	306	165	165	306
GF	11	Operations – 1 FTE- all grants	133	153	286	153	153	306
GF	REV1	FFP at 32%	(349)	(404)	(753)	(404)	(404)	(808)
GF	15	Crisis Response - Contracts	150	150	300	150	150	300
GF	58	Consultation grants	1,000	1,000	2,000	1,000	1,000	2,000
GF	15	Consultation grants- 2 FTE's	277	322	599	322	322	644
GF	57	HCBS Mobile Crisis grants	4,000	8,000	12,000	8,000	8,000	16,000
GF	57	Tribally Based Mobile Crisis grants	1,000	1,000	2,000	1,000	1,000	2,000
GF	15	HCBS Mobile Crisis grants admin - 2 FTE	170	306	476	306	306	612
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
			7	7		7	7	

Change Item Title: Reducing Disparities and Addressing the Opioid Epidemic

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	27,256	17,715	17,533	17,533
Revenues	0	0	0	0
Other Funds				
Expenditures	6,646	2,829	2,829	2,829
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	33,902	20,544	20,362	20,362
FTEs	14	16	14	14

Recommendation:

Across the state, children, grandchildren, siblings, parents, grandparents, cousins, friends and neighbors are dying from opioid use disorders at exceedingly high rates. With lives on the line, Minnesotans need immediate and courageous action. The Lieutenant Governor and Governor recommend bold reforms and investments to increase equitable outcomes for people impacted by the opioid epidemic and to stop the tragic loss of life.

This proposal includes the following provisions:

1. Opiate Epidemic Response Advisory Council (OERAC) membership modifications to ensure Tribal Nations, urban American Indian/Indigenous populations, and African American/Black communities are appropriately represented;
2. OERAC grant making requirements that dedicate resources to disproportionately impacted communities;
3. Ongoing base funding for Traditional Healing grants;
4. Ongoing base funding for Overdose Prevention grants;
5. Technical clarification of settlement fund appropriations;
6. Removal of the sunset on fees from opioid manufacturers and distributors;
7. Funding for competency-based training for substance-use disorder provider community;
8. Family treatment program regulation simplification workgroup and start-up/capacity-building grants;
9. Requirements for treatment settings, schools, publicly funded housing programs, jails, and prisons to have Naloxone on-site and funding for training;
10. Public awareness campaign for harm reduction and youth education;
11. Implementation of a bad batch overdose surge text alert system;
12. Establishment and funding for safe recovery sites;
13. Funding for culturally-focused syringe service programs and needle exchange programs; and
14. Technical assistance center for culturally-specific organizations.

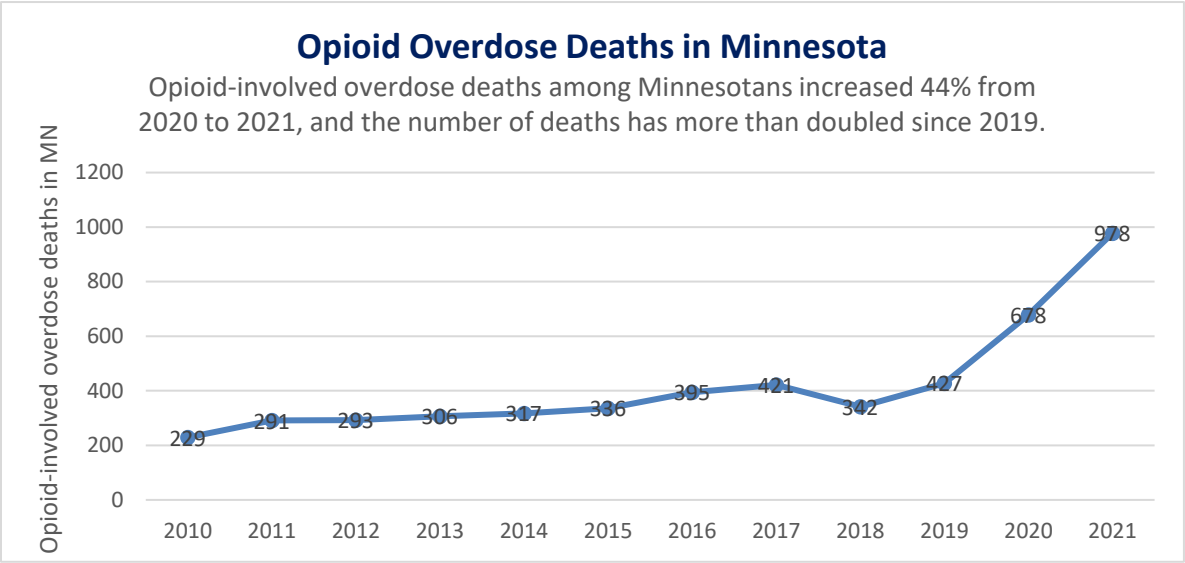
This proposal has an overall fiscal impact of $33.863 million in FY2024-FY2025 and $20.383 FY2026 and FY2027. Funding is appropriated from the Opiate Epidemic Response Account in the Special Revenue Fund as well as the General Fund.

Rationale/Background:

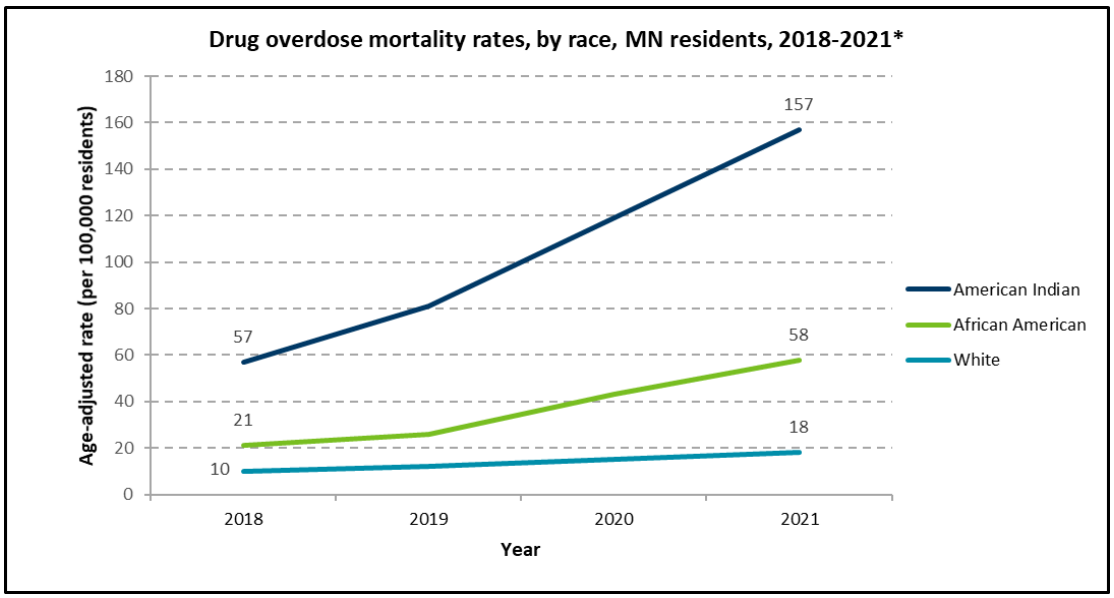
In the late 1990s, pharmaceutical companies reassured the medical community that patients would not become addicted to opioid pain relievers and healthcare providers began to prescribe them at greater rates. Increased prescriptions of opioid medications led to widespread misuse of both prescription and non-prescription opioids

before it became clear that these medications could indeed be highly addictive. In 2017, the United States Department of Health and Human Services declared the opiate crisis to be a public health emergency.

The current state of the opioid crisis in Minnesota is alarming. Between 2000 and 2020, the number of annual opioid deaths increased from 54 to 655 per year. The trend is escalating; between 2020 and 2021 alone, the number of deaths increased by 44 percent.



Minnesota has the worst disparities in the nation when it comes to opioid use disorder outcomes. While the white mortality rate of 10.7 per 100,000 is one of the lowest rates in the nation, Black Minnesotans are three times more likely than white people to die from opioid overdose and Native Minnesotans are 10 times more likely than white people to die from opioid overdose. The disparate outcomes are increasing. In 2020, 131 per 100,000 American Indians experienced opioid overdose deaths, compared to 49 per 100,000 African American residents and 16 per 100,000 white residents. In 2021, 192 per 100,000 American Indians experienced opioid overdose deaths, compared to 67 per 100,000 African American people and 19 per 100,000 of white people. Between 2020 and 2021 American Indian overdose deaths increased by 47%, African American deaths increased by 37%, and white deaths increased by 19%.



The Opiate Epidemic Response Advisory Council (OERAC) was authorized by the 2019 Legislature to develop and implement a comprehensive, statewide effort to address opiate addiction and overdose in Minnesota. The council makes recommendations to DHS on funding priorities and works with DHS and MMB to develop measurable outcomes that assess the efficacy of funds allocated to address the epidemic. The council includes legislators, providers, advocates, county and tribal representatives, and state agency staff. Funding for the Opiate Epidemic Response Account is collected through registration and license fees assessed by the Board of Pharmacy, as well as funds from settlements between the state and opioid manufacturers.

Proposal:

This proposal addresses the opioid crisis by making a series of policy reforms and investments aimed at improving outcomes for all Minnesotans.

1. Modifying OERAC membership

The opiate epidemic has drastic and increasing disproportionate impacts across the state. In 2020, 131 per 100,000 American Indians experienced opioid overdose deaths compared to 49 per 100,000 African American residents and 16 per 100,000 white residents. This provision makes four changes:

- Modifies OERAC membership to add a member from each sovereign tribal nation;
- Modifies OERAC membership to add two members who represent urban American Indian/Indigenous populations;
- Modifies OERAC membership so that the future voting membership composition includes at least 30 percent African American/Black members; and
- Removes the requirement that half of DHS appointed members live outside the seven-county metropolitan areas.

Effective July 1, 2023, this provision expands tribal membership on the Opiate Epidemic Response Advisory Council to include a representative from each of Minnesota's eleven tribal nations, as well as two additional members representing American Indians who reside in urban areas of the state. Statute currently only allows for representatives of the Ojibwe and Dakota tribes and not a representative from each federally recognized tribal nation. The current membership of the council does not provide for adequate representation of tribal nations or urban American Indian populations. Tribal Nations have sovereign status and should be honored as independent entities in governmental affairs. In addition, this proposal requires that at least 30% of OERAC voting members are African American/Black by July 2025. To effectuate these changes and ensure ongoing diverse council composition, this proposal removes the requirement that at least one-half of DHS appointed members reside outside of the seven-county metropolitan area. Around sixty percent of Minnesotans live in the seven-county metropolitan area and that figure is expected to steadily grow to seventy-five percent over the next 20 years. DHS appointed membership will maintain the statutory requirement to balance geographic, racial, and gender diversity. The overall cost for these additions is $66,000 per year for per diem and travel costs for the new members.

2. *Dedicating resources to disproportionately impacted communities*

This provision requires that at least 50% of OERAC grants are distributed to culturally-specific or culturally-responsive initiatives. The State must be intentional when trying to curb OUD disparities and ensure ongoing prioritization of disproportionately impacted and underserved communities. Black Minnesotans are three times more likely than white people to die from opioid overdose and Native Minnesotans are 10 times as likely as white people to die from opioid overdose.

3. Traditional Healing Grant Funding

Effective July 1, 2023, this provision would add traditional healing grants into ongoing funding. The grants are currently set to expire at the end of fiscal year 2024. As a result, ongoing funding is needed starting in fiscal year 2025. Traditional healing grants are awarded to all Tribal Nations and to five urban Indian communities for

traditional healing practices to American Indians and to increase the capacity of culturally specific providers in the behavioral health workforce. The total investment is $2 million per year.

Research consistently points to the value of traditional healing practices designed and delivered by American Indians, for American Indians. Traditional healing for American Indians has outcomes equivalent to conventional interventions in other populations. Traditional healing is proven to:

- Address whole health and the root cause of inter-generational trauma
- Promote self-esteem and resiliency
- Prevent substance use disorders and promote recovery from substance use disorders
- Reach community members adverse to Western models of care
- Increase health and wellness
- Keep families intact
- Help with identity formation and/or reclamation
- Provide adaptive coping skills
- Connect children, adults and elders and promote positive community integration and presence
- Help assign meaning and purpose to life

4. Overdose Prevention ongoing funding

Effective July 1, 2023, this provision extends overdose prevention grants into ongoing funding. The grants are currently set to expire at the end of fiscal year 2024. Ongoing funding ensures dedicated resources are used for overdose prevention. The total investment is $100,000 per year.

5. Correction of Settlement Language Error and Administrative Resources to Oversee Opioid Funds

This proposal corrects a drafting error that occurred in the 2022 legislative session to ensure that opioid settlement funds are distributed as intended. After this correction is made, additional settlement funds directed to the Department of Human Services for grants recommended by the Opiate Epidemic Response Advisory Council are estimated to be $6.303 million in FY 2024 and $342,000 ongoing.

This proposal also includes two FTEs required to administer opioid funding to counties and initiative Tribes to provide child protection services to children and families who are affected by addiction.

6. Removing the sunset on fees from opioid manufacturers and distributors

This provision removes sunset provisions under Minn. Stat. 256.043 for the reduction of licensing fees and repeal of registration fees for opioid manufacturers. This change ensures ongoing revenue to address the primary impacts of the opioid epidemic and the long-lasting tertiary impacts that will require extensive healing for communities across the State.

Under current law, if Minnesota receives $250M (1) because of a settlement agreement related to the marketing, sale, or distribution of opioids; (2) from opioid manufacturer application and renewal fees and registration fees; or (3) from a combination of both, application and renewal fees from drug manufacturers of opiate-containing controlled substances licensing fees would be reduced and opiate registration fees would be repealed. The fee reduction and repeal cannot occur before July 1, 2031. Because the current fee sunset cannot occur before July 1, 2023, removing the sunset provisions is budget-neutral in the current budget horizon.

7. Competency-based training funding for substance-use disorder provider community

This provision expands work currently underway between the DHS and the University of Nevada to provide clinical training supporting the transition to American Society of Addiction Medicine (ASAM) standards. Training efforts funded by this provision include:

- **Establishing a DHS mentorship training of trainers (ToT) Cohort**. Establishing a responsive instructional environment for DHS and others, to create and embed ASAM expert trainers throughout the state. The Minnesota ASAM trainers will establish curriculum responsive to the training needs of clinicians

statewide. Trainers will maintain and update curriculums based on the current and future editions of the ASAM Criteria.

- **ASAM Integration 6-week Enhanced Professional Learning Series (EPL)**. The 6-week online sequenced learning event model uses cutting edge technologies and instructional/consultation activities to increase knowledge, build skills, and change practice through the adoption of evidence-based practices (EBP) and promising practices by behavioral health professionals.
- **Intensive Technical Assistance (ITA) Sessions (ASAM Live)**. Live consultation sessions are an online opportunity for Substance Use Disorders and Recovery Support Services providers to obtain real time input on ASAM delivered by subject matter experts. Each session is an open, one-hour forum guided by participants' questions with responses provided by ASAM experts. The goal of live consultation is to serve as another tool to increase knowledge, build skills, and change practice through the adoption of EBP and promising practices.

This provision will include $150,000 per year starting in FY 2024 for additional funding for more providers to participate in ASAM trainings. In addition, it will require two FTE's, including one MAPE 17L who will focus on developing training opportunities supporting providers at all levels of experience with the ASAM Criteria. This FTE will assist in the creation and education of the model to new entities. In addition, this person will participate in evaluation efforts, state law changes and adjustments to licensing requirements, as needed. The second FTE, a MAPE 14, will be needed to support the coordination of training and coordinate with other entities to train clinicians statewide.

8. Strengthening families work group and family treatment capacity-building/start-up grants

This provision establishes a workgroup for DHS behavioral health and licensing and family treatment providers to identify burdensome, unnecessary regulatory requirements that do not add value or provide health and safety assurances. The workgroup will co-create administrative and/or legislative recommendations to improve access to and quality of family treatment programs. The workgroup and/or subcommittees will also make recommendations on treatment and supportive services that foster family acceptance and support, as well as strong parent-child attachment to ensure Black, Native, and LGBTQ+ youth are supported in navigating stigma and bias and preventing the development of substance-use disorders during adolescence and young adulthood. For this provision, $10,000 is appropriated in FY 2024 and another $10,000 in FY 2025.

In addition, this provision establishes start-up and capacity grants for family substance use disorder treatment programs to improve existing facilities and expand access to new programs. A one-time appropriation of $10 million in FY 2024, and available up to five years, will be used for:

- Renovations to support larger family units;
- Supporting the expansion or development of programs that provide whole family services including trauma supports, conflict resolution, and parenting skills;
- Increasing awareness, education, and engagement utilizing culturally-responsive approaches to bridge gaps and build relationships between culturally-specific communities and clinical treatment provider programs;
- Expanding culturally-specific family programs and culturally adaptive intervention for women's recovery services and ensuring eligibility includes diverse family unit compositions (matrifocal, patrifocal, conjugal, avuncular, extended, chosen, multigenerational, and LBGTQ+ families).

Two MAPE 14 FTEs will be needed for the Behavioral Health division to support the Request for Proposal process (RFP) and grant management as well as stakeholder engagement, facilitating workgroup efforts and collaboration between community, government, and providers. An additional MAPE 17 position in Operations is needed oversee the capital bonding activities provided for these grants. All three positions are time limited and will expire after the end of the five years.

9. Require treatment settings, schools, publicly funded housing programs, jails, and prisons to have Naloxone on-site & provide funding for training

This provision requires treatment programs, public schools, publicly funded housing programs, jails, and prisons to have Naloxone onsite in the case of overdose. It also provides funding for Naloxone administration training. Currently in Minnesota, licensed SUD treatment programs are not required to have naloxone onsite. In an effort to save as many lives as possible, this proposal takes a bold approach requiring all SUD treatment facilities to have naloxone on site and expands the requirements to public schools, publicly funded housing programs and state/local jails and prisons. In addition to ensuring programs have naloxone onsite, annual staff trainings on overdose symptom identification and proper naloxone administration will be required and funded. All staff, not just medical staff, must be able to identify overdose symptoms and conduct first line intervention. In order to save lives, we must leverage evidence-based harm reduction strategies by increasing access to naloxone.

Starting in FY 24, an appropriation for naloxone grants of $1.5 million per year will be provided for training resources to these sites. One MAPE 14 FTE will be needed to develop the RFP and administer the grants.

10. Harm reduction and youth public awareness campaign

This provision would allow the State to contract with an entity to develop a public awareness campaign that targets the stigma of opioid use disorders and aims to prevent and educate youth of the dangers associated with opioids and other substances. It will focus on methods that are proven to have greater impact of communities that are disproportionately affected by opioid use disorder. The public awareness campaign would begin in the spring of 2024 with an estimated ongoing cost of $300,000 per year. The campaign would include a tiered approach including using multiple languages and would use city buses, online ads, TV and radio commercials and billboards and other means of advertising. The $300,000 appropriation would include a contract with a substance Use disorder communications specialist and a public awareness contractor.

11. Bad batch overdose surge text alert system

Currently, there is no statewide, real-time overdose surveillance system in Minnesota and no statewide overdose spike alert system. This provision aims to address both needs through the collation of existing data systems that capture near real-time suspected non-fatal overdoses. Enhancing the central alert system will increase the timeliness, comprehensiveness, and access to overdose data for state and community partners. It will empower communities to access overdose-related data in a way that will support a community-specific, multi-sector overdose spike response, as well as targeted overdose prevention and intervention efforts.

The text alert system has an ongoing cost of $250,000 per year starting in FY 2024. The actual implementation of the system would start in the fall of 2024 (FY 2025) but implementation and planning costs are needed in FY 2024. One MAPE 17L FTE is needed for both the public awareness campaign and the text alert system. This position would begin in FY 2024.

12. Safe recovery sites

The State can play a leading role in preventing overdose deaths. Safe recovery sites can provide people with access to life-saving services while reducing impacts of opioid-use on communities and first responders. Around the world and in a several locations in the United States, these sites successfully engage with populations of people with opioid use disorders who are not connected with community health programs or other health and human service systems. These populations often avoid SUD treatment and mainstream healthcare due to stigmatization and subsequent, sustained societal marginalization. Safe recovery sites have proven to foster trusted and stabilizing relationships for marginalized populations. They have proven to be effective in: reducing infections and the spread of communicable disease; increasing rates of entry into SUD treatment; and reducing neighborhood disturbances such as public injection, improper syringe disposal, and injection-related litter. In

addition, there is compelling evidence that safe recovery sites can have a substantial impact on reducing mortality from overdose. [1][2][3]

This provision would establish start-up and capacity funding for up to 15 safe recovery sites in Minnesota. These sites would be centers of hope, compassion, and acceptance where no human life is viewed as disposable and where possibilities of healing and recovery are embraced. The sites could offer supplies and services, including the following:

- Safe injection spaces;
- Sterile needle exchange;
- Naloxone/Narcan (rescue, safety, emergency) kits;
- Oxygen, fluids, and health monitoring;
- Fentanyl testing;
- FTIR testing machines
- Education and referrals to SUD treatment and recovery services, mental health services, housing, nutrition, health care, holistic supports, and other services; and
- Dignified spaces for people to shower, access hygiene, and to commune without shame.

Safe recovery sites would be operated by independent organizations, funded through a combination of grants and private donations. The funding proposed could allow for 15 sites. RFP's would be chosen based on applicants' proposed work plans and ability to provide services to the greatest number of people based on treatment admission data focusing on county of residence for the previous two years. Funding for community engagement and program evaluation is also included in this provision. Program evaluation will include health related outcomes, as well as public safety and broader community impacts.

The funding would be allocated through competitive grants with an appropriation of $12.5 million in FY 2024 with the ability to carryforward unspent funds into FY 2025 and another appropriation of $12.5 million per year thereafter. Four FTEs would be required to implement this program. A MAPE 17L position in the Behavioral Health Division would be needed to begin work in FY 2024 to provide community education and engagement, write and announce the RFP, accept applications and execute contracts in the spring of 2024. Two additional MAPE 14L positions will be needed in FY 2025; one to provide grant management and the other to provide evaluation of the program. Another FTE will be needed for working with the grant manager on the contract and budget development. Another $100,000 starting in FY 2025 would be invested for a contract to support evaluation of Recovery Sites Grant efforts. The evaluation would address a number of opportunities. The evaluator would work with each grantee on the services they are providing and determine what metrics would determine whether their efforts are successful.

13. Funding for culturally-focused programs to purchase clean needles, testing supplies, and Naloxone

This provision will increase and expedite funding and supplies to Native and Black communities to purchase syringes, testing supplies, and naloxone. Funding will be sole-sourced to community organizations to the extent possible, in an effort to direct urgent resources to communities that need them and know how best to reach their members and respond individualized needs. The total grant appropriation of $500,000 would start in FY 2024 and would be on an ongoing basis. One MAPE 14 position would be needed to manage the contracts and lead community engagement.

[1] Milloy, M.J., et al., Estimated drug overdose deaths averted by North America's first medically-supervised safer injection facility. PLoS One, 2008. 3(10): p. e3351.
[2] Kolber, M., et all, Does Evidence Support Supervised Inject sites?, Can Fam Physician, 2017 Nov; 63(11): 866.
[3] Gostin LO, Hodge JG, Gulinson CL. Supervised injection facilities: legal and policy reforms. JAMA. 2019; 321(8):745-746.

14. Technical assistance for culturally-specific organizations

This provision will establish technical assistance support to expand culturally-specific and responsive substance use and recovery programs. DHS staff will support new and prospective culturally-specific providers to navigate complex systems, advocate for systemic simplifications, and support the expansion of culturally-specific programs. Specific staff members will be available to support programs one to one. This provision also includes support for organizations in the forms of education, empowerment, and resources so programs can be successful in procurement processes and know how to access business development resources.

- **Culturally Specific Technical Assistance positions:** (2- 17L): These positions will work independently to support culturally specific behavioral health providers in navigating the licensure/certification process as well as enrollment with MHCP. They will be responsible for the ongoing technical assistance with these providers and lead efforts to reduce barriers to cultural communities through legislative and policy reforms. These staff will work closely with several areas of DHS (Licensing, BHD, American Indian section, Provider Eligibility and Compliance, and SME's) in order to provide clear and accurate information and provide warm handoffs.
- **Grant development trainings:** $200,000 would support 4 trainings over the two years to provide opportunities to community members to engage in grant writing training for free that are supported by the state. (4 trainings, each for $50,000 – 2 in SFY 24 and 2 in SFT 25)
- **Culturally specific services:** $1,000,000 per year would provide grant funding to support the unique needs of culturally specific providers. Funds could be used to hire grant writers or fundraising consultants, cultural advisors, resources to support cultural practices, for examples, materials to make dream catchers or to support sweat lodge facilitation, or education to develop an individual's sense of community and connection to their roots.

Impact on Children and Families:

This proposal may positively impact families and children from American Indian, Indigenous, African American, and Black families. First, having more equitable representation on the Opiate Epidemic Response Advisory Council will allow for a more inclusive discussion and recommendations from the council on how to respond to the opioid epidemic in our state.

Next, addressing opiate use among parents and potential exposure to children would improve outcomes for children and families. Chronic opiate exposure to the unborn baby during the mother's pregnancy or upon abrupt discontinuation of opioid after birth can result in newborns showing signs of opiate withdrawal, termed Neonatal Abstinence Syndrome (NAS) or Neonatal Opiate Withdrawal Syndrome (NOWS). NOWS is characterized by a wide array of symptoms including increased irritability, hypertonia, tremors, feeding intolerance, watery stools, seizures and respiratory distress, etc.

From 2010 to 2014, rates of NOWS more than doubled in Minnesota. Babies that are born with NOWS are more likely to be born preterm, have low birth weight and have inadequate or no prenatal care. It is important to remember that not all mothers of babies born with NOWS are diagnosed before birth as being dependent on opiates, not all pregnant women dependent on opiates give birth to a NOWS baby. Therefore, opiate dependency in some percentage of pregnancies will remain unknown as there is no universal screening for substance use disorders in pregnancy.

Additionally concerning are the disparities that occur in NOWS. More than one in ten pregnancies among American Indian women have a diagnosis of opiate dependency or abuse during pregnancy. NAS occurs when newborns withdraw from opiates due to maternal opioid use during pregnancy. In Minnesota, there is an 8-fold higher rate of NAS among infants born to American Indians.

Equity and Inclusion:

Minnesota has the worst disparities in the nation when it comes to opioid use disorder outcomes. While the white mortality rate of 10.7 per 100,000 is one of the lowest rates in the nation, Black Minnesotans are three times

more likely than white people to die from opioid overdose and Native Minnesotans are 10 times more likely than white people to die from opioid overdose. The disparate outcomes are increasing. In 2020, 131 per 100,000 American Indians experienced opioid overdose deaths, compared to 49 per 100,000 African American residents and 16 per 100,000 white residents. In 2021, 192 per 100,000 American Indians experienced opioid overdose deaths, compared to 67 per 100,000 African American people and 19 per 100,000 of white people. Between 2020 and 2021 American Indian overdose deaths increased by 47%, African American deaths increased by 37%, and white deaths increased by 19%.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

This proposal aims to have a positive impact on Tribes by providing additional membership on the OERAC and funding to support traditional healing practices and culturally responsive initiatives.

Impacts to Counties:

The OERAC provisions of this proposal do not have a substantive impact on counties.

IT Costs

There are no systems impacts in this proposal.

Results:

1. Opioid overdose deaths will decrease.
2. The disproportionality in opioid overdose deaths will decrease.
3. OERAC grants that serve disproportionately impacted populations will increase.
4. Traditional healing practices and evaluations will continue.
5. Overdose prevention grants will continue, and organizations will have the means to save lives.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			27,256	17,715	44,971	17,533	17,533	35,066
HCAF								
Federal TANF								
Other Fund			6,646	2,829	9,475	2,829	2,829	5,658
Total All Funds			33,902	20,544	54,446	20,362	20,362	40,724
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
SR-OERA	15	Opioid Advisory Council	66	66	132	66	66	132
SR-OERA	59	Traditional Healing grants	-	2,000	2,000	2,000	2,000	4,000
SR-OERA	46	Prevention Grants	-	100	100	100	100	200
SR-OERA	59	Opioid Settlement Technical Correction	6,303	342	6,645	342	342	684
SR-OERA	12	CFS admin - Child protection grants	277	321	598	321	321	642
GF	15	BHDH admin (2 FTEs) Competency Based Training	274	318	592	318	318	636
GF	REV1	FFP@32%- Competency based training	(136)	(150)	(286)	(150)	(150)	(300)
GF	15	Competency training	150	150	300	150	150	300

GF	15	Workgroup- prevent addiction for children,	10	10	20	-	-	-
GF	11	Operations FTE - capital/bonding	145	165	310	165	165	330
GF	15	BHDH Admin (2 FTE)- Prevent addiction for children, youth and families	265	306	571	306	306	612
GF	REV1	FFP@32%- prevent addiction	(134)	(151)	(285)	(151)	(151)	(302)
GF	59	CSF Treatment grants- prevent addiction for children, youth, and families	10,000	-	10,000	-	-	-
GF	59	Naloxone Grants	1,500	1,500	3,000	1,500	1,500	3,000
GF	15	FTE-Naloxone grants	133	153	286	153	153	306
GF	15	Public awareness campaign	300	300	600	300	300	600
GF	15	Bad Batch overdose surge text alert system	250	250	500	250	250	500
GF	15	BHDH admin- FTE for campaign awareness and text alert	145	165	310	165	165	330
GF	REV1	FFP@32%- campaign awareness and text alert	(222)	(229)	(451)	(229)	(229)	(458)
GF	15	BHDH Admin (1 FTE) - reducing harm	145	165	310	165	165	330
GF	15	BHDH admin (2 FTE) Reducing Harm	-	265	265	306	306	612
GF	15	BHDH admin- budget and contract processing (reducing harm)	133	153	286	153	153	306
GF	REV1	FFP@32%	(121)	(219)	(340)	(232)	(232)	(464)
GF	15	Support evaluation- contracts- reducing harm	-	100	100	100	100	200
GF	59	Recovery sites grants	12,500	12,500	25,000	12,500	12,500	25,000
GF	15	BHDH admin- 1 FTE- reduce harm tribes	133	153	286	153	153	306
GF	REV1	FFP@32%- reduce harm tribes	(42)	(49)	(91)	(49)	(49)	(98)
GF	59	Safe Recovery grants- reduce harm, tribes, urban native and black program	500	500	1,000	500	500	1,000
GF	15	BHDH admin- 2 FTE- expediting resources	283	330	613	330	330	660
GF	REV1	FFP@32%- expediting resources	(155)	(170)	(325)	(170)	(170)	(340)
GF	59	Grant training contracts- expediting resources	200	200	400	-	-	-
GF	59	Culturally responsive grants- expediting resources	1,000	1,000	2,000	1,000	1,000	2,000
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	15	BHDH admin	11	13		11	11	
OER	13	CFS Admin	2	2		2	2	
GF	11	Operations	1	1		1	1	

Statutory Change(s):

256.042; 254B; uncodified law

Change Item Title: Expediting Access to Behavioral Health Services

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	13,378	17,683	17,768	17,852
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	13,378	17,683	17,768	17,852
FTEs	**7**	**7**	**7**	**7**

Recommendation:

The Governor recommends strategic investments to facilitate and expedite access to substance use disorder (SUD) treatment services. This proposal invests $31.061 million in state fiscal years 2024-25 and $35.620 million in state fiscal years 2026-27.

This proposal does the following:

1) Allows hospitals, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs) to provide comprehensive assessments without a treatment program license;
2) Maintains a budget neutral SUD administrative funding formula for counties and Tribal Nations and funds actuarial analysis to revise the formula;
3) Expands Housing with Support for Adults with Serious Mental Illness (HSASMI) and the Projects for Assistance in Transition from Homelessness (PATH) grants;
4) Establishes a public awareness campaign for people who use public health care programs to access SUD treatment and;
5) Provides temporary funding in FY 2024 and FY 2025 to the White Earth Nation for Adult Mental Health Initiative (AMHI) capacity building.

Rationale/Background:

According to the Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health, "Among the 21.6 million people aged 12 or older in 2019 who needed substance use treatment in the past year, 12.2 percent (or 2.6 million people) received substance use treatment at a specialty facility in the past year." This means that, nationally, over 80% of people who may benefit from substance use disorder treatment are not getting it. There are various reasons for this rate, however, one well known barrier to those getting help is access.

In Minnesota, the need for improved access to SUD treatment services dates back to a 2006 Office of the Legislative Auditor report on Substance Abuse Treatment, which recommended that DHS strengthen its oversight of local assessment and referral practices. The historic Rule 25 process was improved in response to that report, however the need for additional reforms became evident in 2012, when the Legislature directed DHS to collaborate with counties, tribal nations, and other stakeholders to develop a model of care to improve the effectiveness and efficiency of SUD treatment services. In response to that direction, DHS formed a steering committee. One of the focus areas of the steering committee was improving access to treatment and the assessment process for SUD treatment. The steering committee determined that significant complications existed in the placement authority process:

> "Significant complications exist with the current assessment process that are exacerbated by occasional local jurisdictional enactment of pre-determined blanket cost-containment policies that prevent timely access to assessment, treatment, and restrict the number of hours, days, types and modalities of research supported services appropriate to the severity of illness. Funding mandates for treatment have influenced placement decisions in some areas and this has resulted in inconsistent placement decisions across the state. The current process has created barriers that impede access to appropriate services and can result in significant harm to individuals seeking treatment, their families and communities."[1]

In addition, in 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA) review of Minnesota's placing authority assessment and placement practices highlighted these issues and described them as creating a potential 'bottleneck' for timely access to SUD treatment. The Centers for Medicare and Medicaid Services (CMS) also informed DHS that they were unwilling to renew the State's 1915b waiver that allowed us to restrict choice of SUD provider. That waiver expired in July 2022 and Minnesota no longer has authority to restrict choice of SUD provider for public health program enrollees.

Based on recommendations from the 2012 steering committee and federal guidance from SAMHSA and CMS, Minnesota established a new, more efficient and person-centered assessment process called "Direct Access." Today, Direct Access is fully implemented. Prior to the implementation of Direct Access, only lead agencies could conduct SUD assessments and determine placement. Following implementation, 245G treatment providers and certain licensed professionals may be eligible vendors for providing comprehensive assessments. Still, there are some statutory barriers for FQHCs, RHCs, and hospitals to receive reimbursement for the assessment, absent a 245G license.

Currently, Counties and Tribes are eligible to receive administrative expenses that incur when supporting people to access SUD treatment. The current formula is outdated and based on the percentage of claims from the behavioral health fund to access treatment. The current funding model has not been rebased since 2010 and does not represent an equitable distribution of funds. For example, Mahnomen County did not claim any BHF eligible individuals during the rebasing year which has resulted in no funding over the last 12 years. In addition, the formula does not reflect the supports the County or Tribal evolved roles, post Direct Access.

In addition to clinical treatment, people with SUDs can benefit from expanded access to supportive housing services that provide social supports, care coordination, trauma-informed care, and personal choice. SUDs increase a person's risk of homelessness and people experiencing homelessness are more likely to have opioid use disorders (OUDs) and overdoses. In Minnesota, recent research has highlighted a disturbingly high correlation between people experiencing homeless and death due to opioid overdose. DHS currently administers two grant programs that support people experiencing homelessness or who recently experienced homelessness. The Support for Adults with Serious Mental Illness (HSASMI) and the Projects for Assistance in Transition from Homelessness (PATH) both support this population, however people with SUD as a standalone diagnosis are not currently eligible.

Proposal:

This proposal does the following:

(1) Hospitals, FQHCs, and RHCs as eligible vendors of comprehensive assessments

This provision invests in Medicaid Management Information System (MMIS) and Minnesota Provider Screening and Enrollment (MPSE) portal changes that will add a new provider type, so that individuals can enroll to provide comprehensive assessments as the rendering provider, under a larger billing entity. It also includes short-term increased staff resources in the provider eligibility and compliance area of DHS to support initial implementation. The proposal allows hospitals, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs) to

[1] https://www.leg.mn.gov/docs/2013/mandated/130622.pdf

provide comprehensive assessments without a treatment program license. This proposal also has a small cost for Medical assistance as it produces a 5% increase in the number of fee for service assessments. The cost is $4,000 in FY 24, $33,000 in FY 25 and $52,000 on an ongoing basis.

(2) County & Tribal Administrative Allowance

This provision ensures current county and Tribal administrative allowance allocations do not decrease by setting an allocation floor of 133% of the 2009 funding levels, which aligns with about $2.9 million for FY 2023 which is the current forecast projection for this funding. Currently, the administrative allowance is based on a percentage of BHF claims paid per County or Tribal Nation and has not been rebased since 2010. According to the FY22 DHS spending forecast the allocation was just over $2.9M. As Medical Assistance continues to become the primary payer of SUD services, the current formula has resulted in less resources for Counties and Tribes, while the prevalence of SUDs continues to increase. In 2020, the forecasted administrative funding was $4.6M and in 2021 it was $3.9M. However, the November forecast temporarily increases to $3.592 million in FY 2026 but starts decreasing in FY 2027 to $3.541 million. The administrative allowance in its current form could be expected to continue decreasing over time after FY 2027. Setting a floor for this funding will provide stable funding for counties and tribes to support people in accessing SUD treatment and other resources and services that facilitate recovery. Currently, this provision is budget neutral through FY 2027 because the forecast is higher than the floor.

In addition to preventing decreases to county and Tribal administrative allocations, this provision also invests $250,000 in FY 2024 to conduct research and actuarial analysis that informs recommendations to modify the allocation methodology. Basing the methodology on BHF claims does not adequately capture the administrative supports counties and Tribal nations provide to people experiencing substance use disorders. While counties and Tribes are no longer "placing" authorities, they still determine eligibility for the behavioral health fund. In addition, some people may still seek support at the county level, assuming they offer comprehensive assessments or that they still play a role in finding treatment. Lastly, counties and Tribes also assist people with substance use disorders to access other services such as peer services, housing, economic assistance, and other community resources. Recommendations will be due to the legislature by February 2025.

(3) Expansion of Housing with Support for Adults with Serious Mental Illness (HSASMI) & Projects for Assistance in Transition from Homelessness (PATH)

This provision expands the HSASMI and PATH grants to provide supportive services to people with a substance use disorder (SUD) who are homeless, long-term homeless, or exiting institutions who have complex needs and face high barriers to obtaining and maintaining housing. The proposal invests $3 million per year in ongoing funding for HSASMI and $9.067 million in FY 2024, $13.218 million in FY 2025, and $13.586 million in FY 2026 and $13.668 million in ongoing funding for PATH.

Services provided will assist people to transition to and sustain permanent supportive housing and supportive housing which meets evidence-based practice or recovery housing standards. The current base general fund appropriation is $4.550 million per year. Services will be recovery-focused, person-centered, and culturally responsive. To encompass the expanded services, HSASMI will be renamed Housing with Support for Behavioral Health (HSBH).

The PATH program currently serves people having complex needs with barriers to housing. These individuals are often difficult to locate contributing to the difficulty of providing for their basic needs. The PATH grant helps connect people to services and transition out of homelessness. The current funding provides outreach, case management, screening and diagnostic assessments, community mental health, substance use treatment and some housing supports. Currently, the base funding includes $811K in federal funds and $618K in state funds. The expanded funding will enable more providers to provide services and also increase funding for existing providers.

Seven FTEs total are needed to support this expansion. One FTE for the HSASMI grant and three FTEs for the PATH grant is needed to manage the grants and contract work associated with the grants. These positions are MAPE 14L

positions. In addition, two FTEs are needed for the Financial Operations division to also process both grants which are MAPE 11 positions. The Financial Operations division is responsible for establishing the payment process for these grants. Finally, one FTE is needed to administer the funding in the Operations division within the Behavioral Health, Deaf and Hard of Hearing and Housing Division (BHDH) to assist in the contracting and fiscal development and financial monitoring of these grants.

In addition, the proposal includes funding for a contract evaluation for the PATH grant that will be used for determining whether or not the grants are meeting outcomes. The initial contract of $150,000 will be appropriated in FY 2025 which will provide time to determine the initial evaluation of the additional grant funding. Starting in FY 2027, $150,000 will be appropriated on an ongoing basis.

Housing assistance programs for individuals reentering from incarceration are intended to mitigate the negative impacts of homelessness on the reentry process. These forms of housing are considered voluntary and last a minimum of three months post-release. These programs are service-enriched, meaning they provide services such as job training, employment, or substance abuse treatment in addition to temporary or transitional housing options. (Source: https://www.wsipp.wa.gov/BenefitCost/Program/723) This funding increase is likely to lead to better outcomes for communities most impacted by homelessness, namely BIPOC communities. Increasing outreach efforts will expand access to housing and shelter options for people with substance use disorder and improve quality of life for Black, Indegenous, and People of Color.

(4) Public awareness campaign for accessing SUD treatment services under Minnesota's Health Care Programs (MHCP)

This provision provides funding to secure a third-party contract and staff resources to develop and imitative a statewide public awareness campaign for people to access SUD treatment services. The goals of the campaign are to increase awareness of the dangers of illicit and non-illicit drugs, to provide resources on how to access treatment through MHCP, to reduce stigma, and to spread hope, sharing that recovery is possible. A contract with a 3rd party vendor to develop and run a state-wide public awareness campaign to increases understanding on how to access SUD treatment services under the Minnesota Health Care Program (MHCP), initial cost is estimated at $300,000 in FY2024 and $450,000 in FY2025 and ongoing.

One FTE is needed to manage the contract and procurement work as well as the reporting and oversight associated with this contract. This position would be a MAPE 14L that is estimated at an annual ongoing cost of $153,000 for salary, fringe and overhead. The FTE for FY 2024 is phased in with a start date of September 2023.

(5) Adult Mental Health Initiative funding (AMHI) to White Earth Nation

This provision would provide direct funding to the White Earth Nation for FY 2024-2025 for the AMHI program. This funding will be used to build capacity and to ramp up services for the new allocation which is expected to be received in CY 2025-2026. This funding will allow White Earth to innovate, improve services, and serve more individuals. The $300,000 will be appropriated in both FY 2024 and FY 2025.

Impact on Children and Families:

Expanding access for individuals to access services is expected to have a positive effect on children and families. Nationally, deaths due to drug overdose among adolescents nearly doubled from 2019 (282 deaths) to 2020 (546 deaths). In the same time period, the largest increases in these deaths were among adolescent males (deaths more than doubled), as well as Black (deaths more than tripled) and Hispanic (deaths more than doubled) adolescents. Nationally, about 1 in 8 children are living in households where at least one parent has an SUD. Public policy that supports parents to better access treatment services, facilitates whole family healing and reduces the adverse impacts of substance use on children.

A 2020 study found that current use of alcohol during pregnancy among women aged 18-44 increased from 9.2% in 2011 to 11.3% in 2018, while binge drinking (four or more drinks on one occasion) rates increased from 2.5 to

4%.3. In 2020, the Centers for Disease Control and Prevention (CDC) found reports of alcohol use among pregnant women are higher in the first trimester of pregnancy—19.6% of pregnant women reported current alcohol use in the first trimester vs. 4.7% in the second or third trimesters. They also found that over 40% of pregnant women who reported current alcohol use also reported current use of at least one other substance, most commonly tobacco, marijuana, and opioids. FASD prevalence is estimated to range between 1-5%, however those estimates are likely low due to underreporting/diagnosis.

Equity and Inclusion:

In 2021, the number of treatment admissions for SUD treatment was 58,563 (DAANES). These admissions are disproportionate across racial and ethnic group compared to the general Minnesota population. The breakdown by race according for admissions to SUD treatment was 66.29% White, 12.15% African American, 10.53% Native American, 1.49% Asian or Pacific Islander, 3.68% other with 5.86% Hispanic (DAANES, 2021). This is compared to Minnesota's population according to the US Census Bureau: 83% White, 7% Black, 5% Asian, 1% American Indian or Alaskan Native, 3% with 2 or more races, with 5.5% Hispanic.

Although we do not currently track data for persons with disabilities, SAMHSA's publication, Mental and Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities (2019), suggests "People with physical and cognitive disabilities have a higher prevalence of serious mental illness and substance use disorder, (SUD) as well as lower treatment rates for both conditions than do people without these disabilities."

There are a total of 448 DHS licensed SUD programs in the state of Minnesota (this does not include tribally licensed programs or out of state programs enrolled with MHCP). Of the 448 programs, 223 are in the seven-county metro area (Anoka (18), Carver (8), Dakota (25), Hennepin (91), Ramsey (55), Scott (3), and Washington (23)). This leaves some gaps for the rest of the state where some do not have access to SUD service within 100 miles or more.

According to the Department of Health, there are 126 licensed hospitals and 99 rural health clinics in the state of MN. Reviewing MHCP enrollment information, we have 86 FQHCs that could be eligible to provide SUD services. This is a total of 311 new entities that could assist individuals in accessing substance use disorder services, many of which cover greater MN and areas that are more rural.

People served by the PATH and HASASMI grants are more diverse than Minnesota's overall population. In FY2021, 20% of HSASMI participants were Black or African American, 1% were Asian, 11% were American Indian or Alaska Native, 4% were multiracial, and 59% were white. In FY2021, 34% of PATH participants were Black or African American, 1% were Asian, 16% were American Indian or Alaska Native, and 48% were white. Minnesota's overall population is comprised of: 6.4% Black or African American, 4.9% Asian, 1% Native American, and 82% white.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

The White Earth Nation has indicated that additional AMHI funding will help them to better serve community members and improve behavioral health outcomes for their members. American Indian populations are disproportionately represented among PATH and HSASMI service recipients. While American Indians comprise approximately 1% of Minnesota's overall population, they represent 11% of HSASMI recipients and 16% of PATH recipients.

Impacts to Counties:

This proposal is expected to have a positive impact on county budgets via the new administrative funding formula. In addition, FQHCs and RHCs are intended to support underserved communities. Allowing these entities to bill for and provide comprehensive assessments will allow individuals to get the care they need, alleviating county burden. This provision will increase access to treatment in greater Minnesota and rural areas that do not have SUD treatment within 100 miles.

IT Costs

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll						
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)	82,368	16,474	16,474	16,474	16,474	16,474
Total						
MNIT FTEs	1					
Agency FTEs						

System changes are estimated to require 832 hours of work and take approximately 7.5 months to complete with a total initial development cost of $82,368. Work is required to both MPSE and MMIS systems. System work supports hospitals, Federally Qualified Health Centers (FQHC), and Rural Health Clinics (RHC) to provide certain substance use disorder services without a treatment program license

Results:

- Estimated # of additional people experiencing homelessness receiving support from HSASMI : 1,350 people (based on $3M per year)
- Estimated # of additional people experiencing homelessness receiving support from PATH : 4,500 people (based on $5M per year
- Additional access points for people seeking an assessment in order to access SUD treatment

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			13,378	17,683	31,061	17,768	17,852	35,620
HCAF								
Federal TANF								
Other Fund								
Total All Funds			13,378	17,683	31,061	17,768	17,852	35,620
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	MPSE Systems Costs	17	3	20	3	3	6
GF	11	MMIS Systems Costs (FFP @ 29%)	19	4	23	4	4	8
GF	57	Housing with Support for Adults with Serious Mental Illness (HSASMI) Grants	3,000	3,000	6,000	3,000	3,000	6,000
GF	15	BHDH Admin (HSASMI) 1 FTE	133	153	286	153	153	306
GF	15	Contract for PATH	0	150	150	0	150	150
GF	15	Contract for Research Services	250	0	250	0	0	0
GF	57	AMHI - White Earth Grant	300	300	600	0	0	0
GF	57	Projects for Assistance in Transition from Homelessness (PATH) Grants	9,067	13,218	22,285	13,686	13,668	27,354
GF	15	BHDH Admin (PATH) 3 FTE	359	459	818	459	459	918
GF	33	SUD Comprehensive Assessments	4	33	37	52	52	104
GF	15	Minnesota Health Care Program (MHCP) Contract	300	450	750	450	450	900
GF	11	Operations Admin – 2 FTE- HSAMI and PATH grants	250	286	536	286	286	572
GF	15	BHDH Admin - MHCP Contract - 1 FTE	136	157	293	157	157	314
GF	REV1	FFP @ 32%	(457)	(530)	(987)	(482)	(530)	(1,012)
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
			7	7		7	7	

Statutory Change(s):

254B.02; 254B.05, session law

Change Item Title: Improving Quality of SUD Treatment & Alleviating Administrative Burdens

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	1,058	1,190	1,206	1,206
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	1,058	1,190	1,206	1,206
FTEs	**9**	**10**	**10**	**10**

Recommendation:

The Governor recommends investing $2.234 million in fiscal years 2024-25 and $2.412 million in fiscal years 2026-27 to improve access to high-quality and evidence-based substance use disorder (SUD) treatment services. This investment brings Minnesota into compliance with federal requirements, promotes integrated service delivery models, and alleviates administrative burdens for providers.

Rationale/Background:

In 2015 and 2017, CMS announced opportunities for state Medicaid agencies to apply for 1115 Demonstrations to address the opioid crisis. States were instructed to improve access to high quality, clinically appropriate treatment for SUD through the implementation of evidence-based treatment guidelines, such as the American Society of Addiction Medicine (ASAM) Criteria and covering critical levels of care, medication for opioid use disorders (MOUD), and withdrawal management. States are able to receive federal financial participation (FFP) for services provided in Institutions for Mental Diseases (IMDs), defined as residential facilities with more than 16 beds. Federal laws typically exclude IMDs from Medicaid reimbursement.

Minnesota has been moving towards an SUD treatment system aligned with a chronic disease model for SUD for 20 years. DHS' 1993-99 The challenges and benefits of chemical dependency treatment study's key recommendation was to create an SUD continuum of care consistent with chronic disease management. In 2013 Minnesota's Model of Care for SUD Legislative Report (DHS-6708) recommended updating Minnesota's treatment system from an acute episodic model to a chronic, longitudinal model of health care. These reports initiated the early beginnings of Direct Access and ASAM SUD Reforms.

In response to the new opportunities announced by CMS, Minnesota submitted an 1115 SUD demonstration request in 2018. On July 2020, CMS approved Minnesota's implementation plan and Special Terms & Conditions, marking the official start of Minnesota's 1115 demonstration. By expanding the use of the ASAM Criteria and expanding MA coverage to IMDs, Minnesota aims to address six federal goals and objectives:

1) Increased rates of identification, initiation and engagement in treatment for Opioid Use Disorders (OUD) and other SUDs;
2) Increased adherence to, and retention in, treatment for OUD and other SUDs;
3) Reductions in overdose deaths, particularly those due to opioids;
4) Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment when the utilization is preventable or medically inappropriate, through improved access to more appropriate services available through the continuum of care;

5) Fewer readmissions to the same or higher level of care for readmissions that are preventable or medically inappropriate; and
6) Improved access to care for physical health conditions among beneficiaries with SUDs.

As part of our agreement with CMS, Minnesota is required to implement evidenced based services statewide. At this time, evidence-based services are provided through the 1115 SUD Reform Demonstration. Participation in the 1115 demonstration is required for licensed residential SUD and withdrawal management programs enrolled with Minnesota Health Care Programs (MHCP) by January 2024. Nonresidential providers currently have an option to participate. The core components of Minnesota's 1115 SUD demonstration are:

1) The Demonstration's Level of Care Requirements incorporate ASAM Criteria. SUD providers must implement the Level of Care Requirements into their policies and procedures in order to participate in the 1115 Demonstration.
2) The Level of Care Requirements also include patient referral arrangement agreements (PRAAs) for ASAM Levels of Care providers don't offer, medication for opioid use disorders (MOUD) access for residential providers, as well as medical, psychiatric, psychological and toxicology consultation and referrals.
3) Access to all forms of MOUD is an essential component for equitable access and success of treatment. In order to increase access to evidence-based treatment and promote equitable treatment, DHS encourages providers to accept people receiving any FDA-approved MOUD.
4) Residential and outpatient providers who enroll in the Demonstration are eligible for higher base rates. Outpatient programs are eligible for a 20% rate enhancement over the base rate and residential providers are eligible for a 25% rate enhancement over the base rate.
5) CMS also requires Minnesota to implement a utilization management process to assure beneficiaries receive SUD treatment at the appropriate level of care, interventions are appropriate for the diagnosis and include an independent process for reviewing residential treatment placements.

Today, Minnesota has a patchwork of ASAM requirements across various SUD treatment services. Statute and state plan agreements require some components of *ASAM Criteria*, but not the entire framework and guidelines. This has created a multi-layered complex system that is difficult to navigate for all stakeholders, including DHS, providers, and individuals who use treatment services. Disjointed and inconsistent standards have made it difficult for DHS to monitor outcomes and compliance; for providers to managing the clinically unnecessary requirements while meeting people's needs; and most importantly, people are not always receiving the best care, at the right time.

Proposal:

This proposal supports the ongoing transition to ASAM standards and allows a more singular policy focus on innovating and advancing reforms to improve outcomes. This proposal has six components:

1) Reduces paperwork burdens by removing standards not required for health and safety or ASAM;
2) Streamlines requirements for residential services;
3) Adds ASAM levels of care to state law and requires outpatient programs to enroll in the 1115 demonstration by 1/1/2025;
4) Requires all licensed 245G programs to meet minimum co-occurring capable requirements;
5) Implements a statewide utilization management system to ensure Medicaid payment integrity; and
6) Adds staffing for data analysis and evaluation for the Behavioral Health, Housing, and Deaf & Hard of Hearing Services Administration (BHDH).

(1) Reducing paperwork burden for staff

These provisions allow the comprehensive assessment and assessment summary, which are used to determine diagnosis and recommendations for level of care, to be less prescriptive. Core components of the comprehensive assessment will be moved to Chapter 245I (Uniform Service Standards) to support efforts to integrate mental health and SUD provider requirements. These provisions will also extend timelines for treatment plan paperwork based on an individual's level of care, resulting in more person-centered care.

(2) Streamlining requirements for residential services

This provision will remove arbitrary hourly requirements tied to low, medium, and high intensity residential treatment services. Instead of hourly requirements, varying intensity will align with ASAM level of care, preparing the SUD policy infrastructure for upcoming payment rate reforms. This change will allow programs to better respond to individualized needs and ensure individuals are able to participate in the right mix of programming.

This provision will also eliminate what is currently "medium intensity residential" and replace it with ASAM Level 3.1 Clinically Managed Low Intensity Residential Services. It will remove "high intensity residential" and replace it with Level 3.5 Clinically Managed High-Intensity Residential. This provision does not impact nonresidential codes. This provision will require updates to DAANES and MPSE Portals. This system cost will have a state share cost of $14K in FY 24 and $3K ongoing with an overall total cost of about $25,000 in FY 24.

(3) ***Ensure all programs meet ASAM criteria***

This provision is the core of this proposal. It will codify ASAM criteria in Medical Assistance statute (chapter 254B) and require outpatient providers to enroll in the 1115 demonstration so they can receive enhanced payment rates, while meeting Minnesota's obligation to extend ASAM criteria and referral requirements across all SUD state plan services.

This provision includes resources for ongoing ASAM training for providers, including documentation training. It includes one DHS FTE (17L) to establish regular meetings with providers and provide technical assistance, guidance, and training. This individual will work closely with DHS Licensing and the state's contracted utilization management agent to ensure consistent communications to providers. In addition, this provision includes internal funding for DHS to implement a "Train the Trainer" model, so the entire team is well-versed in ASAM and can provide ongoing support to providers. This provision also requires an additional financial operations position, one MAPE 11L.

(4) Ensure programs meet minimal co-occurring requirements

This provision requires all providers to meet ASAM co-occurring requirements and co-occurring capable requirements under 245G.20 to ensure people can benefit from co-occurring services sooner and in a streamlined fashion. These standards will ensure that:

- Treatment centers are staffed appropriately and trained to serve people with co-occurring mental health conditions;
- Programs have access to medical providers with psychiatric expertise;
- Programs have access to a mental health professional for staff supervision and consultation;
- Individual group dynamics are therapeutically designed for people with co-occurring disorders;
- Programs document mental health symptoms, interventions, progress, and collaboration with other health care providers;
- Program materials are adapted for people with mental health conditions;
- Programs have policies that allow flexibility for people who may lapse in treatment or have difficulty in adhering to program rules due to co-occurring mental health conditions, so that all people are set up for successful completion; and
- Programs have individual psychotherapy and case management available during treatment.

(5) Implementing a statewide utilization management system

Utilization management (UM) is a process to manage healthcare costs, ensure that provider services/claims align with medical necessity criteria, and reduce or eliminate care that is wasteful, inefficient, or unnecessary. Currently, the 1115 Demonstration has piloted a comprehensive, independent utilization management process to ensure that beneficiaries have access to the necessary levels of care, that interventions are appropriate for the diagnosis, and that the documentation supports the payment of claims. This proposal will expand the scope of the existing 1115 Demonstration UM process to include all claims regardless of 1115 demonstration enrollment status.

The UM system will review level of care and clinical documentation to verify individuals seeking SUD treatment services receive person-centered care that meets the ASAM level of care being billed for by the provider. Providers will be selected randomly for each quarter, not to exceed 10% of people a provider served for the quarter. The UM agent will review all clinical documentation from time of admission to discharge. If compliance is confirmed, the post-payment review is approved. If compliance is not confirmed, the UM agent notifies DHS. DHS will then meet with the provider and provide additional technical assistance and support for improvement. Ongoing support and monitoring would occur prior to any referrals to DHS Surveillance and Integrity Review Section (SIRS).

There is currently $700,000 per year allocated from the general fund to support UM efforts for the 1115 demonstration. This proposal would provide an additional $320,000 per year to expand UM. DHS will need one FTE (14L) to manage the contract, engage in frequent meetings with the UM agent, staff training and communication. This individual will not only manage the grant contract, but will assist with data collection and recommendations on necessary adaptations/contract amendments needed to ensure payment integrity and that individuals are getting the right services at the right time. This provision includes two FTEs for DHS' Surveillance and Integrity Review Section (SIRS) to further enhance program integrity and oversight.

(6) BHDH Data and evaluation staffing

The BHDH administration does not have sufficient data resources for determining outcomes and gaps in current programs. Without this data, it is challenging to use a methodological, data-based approach to identify needs and improve outcomes for people who use mental health, substance use disorder, housing, and related services. This provision includes an investment in administration-wide staffing for data and evaluation. The funding includes staffing for four staff (one MAPE 17L, 2 MAPE 15L's and one MAPE 14) and one supervisor.

Impact on Children and Families:

Implementing ASAM levels of care establishes a comprehensive continuum of care, allowing individuals to receive the care they need, while they integrate back to daily activities and reconnect with their families. New levels of care will creating opportunities for a low-touch treatment options, preventing potential relapse while maintaining daily activities and family connections. The ASAM Criteria views individuals in their entirety, rather than as single medical or psychological condition. When determining service and care recommendations, The ASAM Criteria pays attention to the whole patient, including all of his or her life areas, as well as all risks, needs, strengths, and goals. In addition to person and family centered assessment and goal planning, ASAM acknowledges that family involvement in a person's recovery has significant benefits for both the person and other members of the family.

Improving the quality of treatment is expected to have a positive effect on children and families. Nationally, deaths due to drug overdose among adolescents nearly doubled from 2019 (282 deaths) to 2020 (546 deaths). In the same time period, the largest increases in these deaths were among adolescent males (deaths more than doubled), as well as Black (deaths more than tripled) and Hispanic (deaths more than doubled) adolescents. Nationally, about 1 in 8 children are living in households where at least one parent has an SUD. Public policy that prioritizes person and family-centered care, facilitates family well-being and reduces the adverse impacts of substance use on children and youth.

A 2020 study found that current use of alcohol during pregnancy among women aged 18-44 increased from 9.2% in 2011 to 11.3% in 2018, while binge drinking (four or more drinks on one occasion) rates increased from 2.5 to 4%.3. In 2020, the Centers for Disease Control and Prevention (CDC) found reports of alcohol use among pregnant women are higher in the first trimester of pregnancy—19.6% of pregnant women reported current alcohol use in the first trimester vs. 4.7% in the second or third trimesters. They also found that over 40% of pregnant women who reported current alcohol use also reported current use of at least one other substance, most commonly tobacco, marijuana, and opioids. FASD prevalence is estimated to range between 1-5%, however those estimates are likely low due to underreporting/diagnosis. Person-centered treatment that addresses all of a person's needs and strengths will help support pregnant people in maintaining healthy pregnancies.

Equity and Inclusion:

In 2021, the number of treatment admissions for substance use disorder treatment was 58,563 (DAANES). These admissions are disproportionate across racial and ethnic group compared to the general Minnesota population. The breakdown by race according to 2021 DAANES data was 66.29% White, 12.15% African American, 10.53% Native American, 1.49% Asian or Pacific Islander, 3.68% other with 5.86% Hispanic. This is compared to Minnesota's population according to the US Census Bureau: 83% White, 7% Black, 5% Asian, 1% American Indian or Alaskan Native, 3% with 2 or more races, with 5.5% Hispanic.

Benefits of this proposal increase equity for cultural and disability providers. By removing the prescriptive legislative requirements and implementing ASAM, which is a more flexible, person-centered approach, this will allow programs to modify their programs to meet the need of individuals they serve. The ultimate goal of this proposal is to ensure individuals receive the right services according to cultural identify and needs, mental health needs, and other individualized clinical and support needs.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:

There may be an impact to counties financially. Implementation of statewide ASAM standards and the requirement for outpatient programs to enroll will result in more demonstration providers. By enrolling in the Demonstration, individuals are more likely to access health insurance than continue to utilize the Behavioral Health Fund. Counties pay a share of services when people are funded through the BHF.

IT Costs

The system changes include updates to the MPSE system and DAANES system. These systems changes are estimated to require 251 hours of work, take approximately 3 weeks to complete, and cost of a total of $25,542 for initial development.

In addition to the initial development costs cited above, the systems changes required in this bill will result in increased ongoing maintenance and operations costs, estimated annually at 20% of the total initial development cost. It is assumed that the state share is 50% of the total cost.

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll						
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)	25,524	5,109	5,109	5,109	5,109	5,109
Total						
MNIT FTEs						
Agency FTEs						

Results:

As a part of the 1115 Demonstration, DHS is required by CMS to evaluate our performance related to enrolled providers meeting ASAM standards. As more providers become enrolled in the demonstration, this data will depict a fuller picture of SUD services.

Summary of data being gathered

- **Reports.** Reporting is an important component of the Demonstration. Federal authority gives Minnesota additional flexibility to design and improve their SUD Medicaid program. Due to the added flexibility the Centers for Medicare and Medicaid Services (CMS) has specific reporting and evaluation requirements. In addition to federal requirements, DHS is conducting ongoing stakeholder engagement.
- Federal deliverables. Federally required reports are published on DHS' Federal health care waivers webpage within 30 days of CMS approval. In addition, DHS submits three quarterly reports and one annual report to CMS each year of the Demonstration. These reports include operational updates, performance metrics, financial reporting, evaluation activities and interim findings, and SUD Health IT updates. Performance Metrics incorporate 35 claims-based measures to track trends related to the six goals and objectives of the Demonstration.
- Independent Evaluation. As part of the Special Terms and Conditions to CMS, DHS is required to work with an independent evaluator to evaluate the Demonstration's implementation and impact on the six goals and objectives. DHS has partnered with the National Opinion Research Center (NORC) to conduct the independent evaluation. The evaluation process includes: evaluation design plan, mid-point assessment, summative evaluation.

Not only does the *ASAM Criteria* address the six goals and objectives of the 1115 Demonstration, it also offers solutions to ongoing concerns in Minnesota's SUD systems. The table below illustrates the current state of affairs and broader systemic outcomes.

Implementing full ASAM – What will ASAM do for Minnesota's SUD system?

Support Medicaid Integrity:

Current State/Concerns	Proposal	Outcome
• No Statewide Utilization Management System • Licensing reviewing many components of 245G/254B	• Create UM system to review appropriate placement/Level of care • Align standards with 245I and put ASAM standards in 254B/245I	• More frequent oversite to Ensure Medicaid payment integrity. • Allows DHS to provide more hands-on technical assistance to support providers success

Reduce Workforce Burnout:

Current State	Proposal	Outcome
• 245G documentation guidelines create clinically unnecessary burden on providers • 30 Hour residential service requirement • LADC workforce burden/definition confusion	• Propose legislation (2023) to incorporate all ASAM levels of care • Changes to comprehensive assessment and summary, treatment plan and treatment plan review to support ASAM's person centered approach • Allow qualified mental health professionals to complete the comprehensive assessment for placement purposes- Alcohol and drug counselor would still be necessary to guide to clinical care of someone in SUD treatment	• Reduce paperwork for providers without sacrificing quality documentation • Focused on clients' needs rather than number of hours • Increase access points to SUD treatment and Comprehensive assessment

Clarifying Clinical Definitions (Levels of Care)

Current State	Proposal	Outcome
• Levels of Care are not defined which impacts continuum of care. • Some providers are not co-occurring	• Add ASAM Levels of CARE into statute • Propose statute to require all providers to meet minimum co-occurring requirements	• Improved continuing care for clients • It will encourage all providers to move into the demonstration without mandating it.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			1,058	1,190	2,234	1,206	1,206	2,412
HCAF								
Federal TANF								
Other Fund								
Total All Funds			1,058	1,190	2,234	1,206	1206	2,412
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	15	BHDH Admin 1 FTE – Utilization Mgmt.	133	153	286	153	153	306
GF	15	Contract Costs – Utilization Mgmt.	320	320	640	320	320	640
GF	15	BHDH Admin – ASAM FTE	141	165	306	165	165	350
GF	15	BHDH Admin – ASAM Contract	50	0	50	0	0	0
GF	11	Financial Operations – 1 FTE	133	153	286	153	153	306
GF	13	HCA Admin – Contract	60	0	60	0	0	0
GF	12	OIG Admin – SIRS 2 FTEs	141	306	447	330	330	660
GF	15	Data Team – 5 FTEs	557	648	1,205	648	648	1,296
GF	REV1	FFP at 32%	(491)	(558)	(1,043)	(566)	(566)	(1,132)
GF	11	MNIT Systems - DAANES	6	1	7	1	1	2
GF	11	MNIT Systems - MPSE	8	2	10	2	2	4
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
			9	10		10	10	

Statutory Change(s):

254B, 245G, 245I

Change Item Title: Sustaining the Behavioral Health Workforce

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund	17,608	17,696	17,696	17,696
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	17,608	17,696	17,696	17,696
FTEs	**6**	**6**	**6**	**6**

Recommendation:

The Governor recommends making investments to sustain Minnesota's behavioral health workforce by (1) increasing funding for the Cultural and Ethnic Minority Infrastructure Grants (CEMIG); (2) increasing funding for Provider Supervision grants; (4) and increasing funding for Psychiatric Residential Treatment Facility (PRTF) start-up and specialization grants.

This proposal has a General Fund impact of $35.304 million in the FY 2024-2025 biennium and $35.392 in FY 2026-2027 biennium.

Rationale/Background:

For more than six years, most of Minnesota has been considered a federally designated mental health professional shortage area, except for the Twin Cities metro area and the southeast corner of the state around Rochester[1]. The metro area is faced with a severe shortage of racial and ethnic minority providers competent to service Black, Indian, and people of color (BIPOC) communities. There is also a severe shortage of professionals who can diagnose and treat substance use disorders, including licensed alcohol and drug counselors, most of whom work in the Twin Cities area[2]. Like all other health care provider types, there is an uneven distribution of licensed alcohol and drug counselors around Minnesota, with the majority practicing in urban areas. Assuming the same share of people need behavioral health treatment in urban and rural areas, rural-based behavioral health professionals face higher patient loads and prospective patients are likely driving longer distances and experiencing longer wait times for care.

The COVID-19 pandemic has negatively impacted many people's mental health and created new barriers for people already experiencing mental health and substance use disorders[3]. More than ever, we need clinical supports and a strong behavioral health workforce to effectively cope with mental health and substance use disorder needs that have increased due to the COVID-19 pandemic.

[1] https://www.health.state.mn.us/facilities/underserved/docs/2016mh.pdf
[2] https://www.health.state.mn.us/data/workforce/mh/docs/cbladc.pdf
[3] https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

The behavioral health field can be a challenging one to work in, with difficult conditions and burnout common. Behavioral health professionals often must understand and comply with varied and complex administrative and regulatory requirements, in addition to navigating complex health care systems in order to receive payment for their services. Furthermore, there has been concern about adequacy of payment rates for some behavioral health services, which may also discourage individuals from entering the field or contribute to individuals leaving for another career choice.

Provider Supervision & Related Workforce Grants

In a period between completion of the masters or doctoral level academic training and achievement of professional licensure, clinical trainees must complete two-to-four years (depending on clinical field) of on-the-job-training, in which they learn the concepts and skills of their professions through performing the assessment and treatment of clients while working in a community clinic setting, under close supervision of an experienced, licensed professional. Supervision and training costs are born by provider agencies who sponsor internships—essentially paying for the privilege of preparing future members of their professions. While trainees' direct service hours may be covered by public or private insurance payments (often at a lower rate), the cost of supervision is not covered by private insurance or Medicaid. Such supervision costs remain the greatest uncompensated burden to expanding the workforce—particularly among small racial and ethnic minority-operated organizations. Many clinics simply cannot afford to hire interns. When clinicians who are Black, Indigenous, or persons of color (BIPOC) do not have the opportunity to prepare BIPOC trainees in the cultural variations of assessment and treatment, BIPOC communities cannot receive the most effective care.

CEMIG grants have been in existence since 2007, and funding remained even at $300,000 per year until the administrative merger of existing state grant appropriations for children's mental health, adult mental, health and substance use disorders in the 2019. Current state funding is $600,000, inclusive of children and adults.

CEMIG grants have been utilized, first, to cover services from culturally specific providers to uninsured and underinsured members of racial and ethnic minority communities and, second, to expand the behavioral health workforce by paying the cost of clinical supervision for clinical trainees completing direct experience hours necessary for mental health professional and licensed alcohol and drug counselor (LADC) licensure.

Increasing Funding for Psychiatric Residential Treatment Facilities (PRTFs)

Psychiatric Residential Treatment Facilities (PRTFs) provide active treatment at an inpatient level of care under the direction of a physician, seven days per week, to youth under age 21 with complex mental health needs and their families, based on medical necessity. PRTFs are not considered Institutions for Mental Disease (IMDs). The PRTF level of care includes daily active treatment, which is achieved through a combination of family, group, and individual therapy, consultation and treatment planning with a comprehensive team of medical and behavioral health staff, and a highly structured living environment. Comprehensive discharge planning begins at the time of admission, to aid in a successful transition to home, school and community as soon as possible.

In 2015, legislation directed the state to enroll up to 150 beds at up to six psychiatric residential treatment facility sites statewide. Subsequent legislation in 2019 authorized an additional 80 beds with no cap on the amount of sites. DHS anticipates a total of 300 beds will be enrolled by 2023. The 2019 legislation also appropriated ongoing funding for PRTF start-up grants to prospective PRTF sites, beginning with $400,000 in FY 2020 and $400,000 in FY 2021[5]. Funding can be used for administrative expenses, consulting services, HIPAA compliance, training programs for staff and clients, allowable physical renovations to the property, and therapeutic resources including evidence-based, culturally appropriate curriculums.

Over the past two years, DHS has been meeting with mental health stakeholders, hospitals, and counties to identify strategies that help transition children and youth from emergency departments to therapeutic treatment settings that meet their needs and better support families. Stakeholders, including current and potential PRTF providers, have indicated that one of the barriers to accepting children and youth from emergency departments is

the lack of specialized staffing structures to treat and support behavioral health conditions such as: neurocognitive disorders, complex post-traumatic stress disorder (PTSD), schizophrenia spectrum disorders, and manifestation of aggressive and sexually inappropriate behaviors. DHS has issued requests for proposals seeking to expand PRTF providers that have the capacity and willingness to specialize in serving these populations.

Proposal:

This proposal includes multiple strategies to behavioral health professionals:

1. Increase funding for cultural and ethnic minority infrastructure (CEMIG) grants

The Cultural and Ethnic Minority Infrastructure Grants (CEMIG) will be increased by $5 million per year starting in FY 24 with funding to expand both mental health and substance use disorder organizations ($10 million total for both programs). This funding will be used for recruiting more Black, Indigenous, and People of Color (BIPOC) providers. This grant program will give funding priority to culturally specific providers. Secondary consideration will be given to mainstream clinics who can demonstrate the capability to deliver services in a culturally responsive manner and who meet other the eligibility requirements of the program.

Individuals eligible for supervision support under this grant program are qualifying persons who are self-identified as Black, Indigenous, person of color, multi-racial, or multi-ethnic, who will receive supervision from a provider organization serving children and families with mental health conditions, substance use disorders, or co-occurring conditions, who are of racial and ethnic minority communities, including racial and ethnic minority individuals and families who also are underserved with regard to national origin, sexual orientation, gender identity, or physical ability. This program will require two FTEs to develop the grant program, the RFP and administer the grant programs.

2. Increase funding for Provider Supervision Grants

The Provider Supervision grant, which was established by the 2022 Legislature will be increased by $5 million per year starting in FY 24. This grant program will be used to recruit mental health providers in rural areas and underserved communities. Grant funds can include reimbursement of supervision costs of interns and clinical trainees, funding to reimburse staff for master's degree tuition costs in mental health fields, and licensing and exam fees. This proposal would also include two FTEs to administer the two grant programs.

3. Increasing Funding for Psychiatric Residential Treatment Facilities (PRTFs)

Effective July 1, 2024, this proposal requests $1 million of funding to provide additional start-up grants and $1.05 million of funding to provide PRTF specialization grants to potential PRTF sites. This funding would potentially fund four new PRTF sites. The specialization grants will fund staffing structures to treat and support behavioral health conditions such as: neurocognitive disorders, complex post-traumatic stress disorder (PTSD), schizophrenia spectrum disorders, and manifestation of aggressive and sexually inappropriate behaviors to better support children and families. The proposal also expands the allowable uses of start-up grants to include emergency workforce shortage uses, as determined by the Commissioner. Allowable grant uses related to emergency workforce shortages may include, but are not limited to, hiring and retention bonuses, recruitment of a culturally responsive workforce, and allowing providers to increase the hourly rate in order to be competitive in the market. As part of this initiative, two FTEs will be needed to administer the grants and assist PRTF providers.

Impact on Children and Families:

Improving access to SUD supportive services is expected to have a positive effect on children and families. Nationally, deaths due to drug overdose among adolescents nearly doubled from 2019 (282 deaths) to 2020 (546 deaths). In the same time period, the largest increases in these deaths were among adolescent males (deaths more than doubled), as well as Black (deaths more than tripled) and Hispanic (deaths more than doubled) adolescents. Nationally, about 1 in 8 children are living in households where at least one parent has an SUD.

A 2020 study found that current use of alcohol during pregnancy among women aged 18-44 increased from 9.2% in 2011 to 11.3% in 2018, while binge drinking (four or more drinks on one occasion) rates increased from 2.5 to 4%.3. In 2020, the Centers for Disease Control and Prevention (CDC) found reports of alcohol use among pregnant women are higher in the first trimester of pregnancy—19.6% of pregnant women reported current alcohol use in the first trimester vs. 4.7% in the second or third trimesters. They also found that over 40% of pregnant women who reported current alcohol use also reported current use of at least one other substance, most commonly tobacco, marijuana, and opioids. FASD prevalence is estimated to range between 1-5%, however those estimates are likely low due to underreporting/diagnosis. Person-centered treatment that addresses all of a person's needs and strengths will help support pregnant people in maintaining healthy pregnancies.

Ensuring children have access to culturally responsive mental health treatment improves the well-being of children and families. The pandemic has taken a heavy toll on the nation's mental health and children are also facing worsening emotional and cognitive health. More than 25% of high school students reported worsening emotional and cognitive health and over 20% of parents with children ages 5-12 reported similar worsening conditions for their children. In addition, there has been a large decline in pediatric mental health care usage since the start of the pandemic. While access to mental health services via telehealth has increased, mental health services via schools likely decreased with closures. Among Medicaid and Children's Health Insurance Program (CHIP) beneficiaries under the age of 18, the number of children receiving mental health services dropped by 50% from February to October 2020. Equally as important, the poor mental health of parents could be a contributing factor in negative mental health outcomes for children.

Equity and Inclusion:

Black/African Americans and American Indians are overrepresented in the mental health and substance use disorder treatment system. Any increase in access to supportive services and funding for related activities is anticipated to have a greater effect on these groups. Black, Indigenous, and Communities of Color are less likely to seek mental health and substance use disorder treatment services when there is a lack of providers who look like them, understand their culture, speak their language, and provide culturally responsive services.

Adolescents, young children, LGBTQ youth, and children of color have been disproportionately impacted by negative mental health consequences during the pandemic. A survey of LGBTQ youth found that many LGBTQ adolescent respondents (ages 13-17) reported symptoms of anxiety (73%) and depression (67%) and serious thoughts of suicide (48%) during the pandemic. Although data is limited on children of color, research suggests that even before the pandemic they had higher rates of mental illness, but were less likely to access care. They were also less likely than White children to have access to school health services, including mental health care. During the pandemic, these access issues may be further exacerbated as school services may have been suspended or limited. Asian children may also be uniquely at risk of adverse mental health outcomes due to anti-Asian racism that has emerged during the pandemic; prior to the pandemic, they were more likely to face barriers to accessing mental health services than White children. Structural racism has been associated with poor mental health outcomes. During the pandemic, Black and Latino adults have also experienced higher rates of illness and death from COVID-19, negative financial impacts, and poor mental health outcomes, which may have adverse mental health effects on children from these communities.

Suicide may also disproportionately affect children of color. Before the pandemic, Native American adolescent girls were three times more likely to die of suicide than White adolescent girls, and suicide rates have been increasing faster among Black children and teens than among non-Black children and teens.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒ Yes
☐ No

Tribes may be eligible to receive provider supervision and CEMIG grants. Tribal Nations have confirmed they are experiencing workforce shortages and are seeking creative solutions and investments to expand and better support their culturally-specific behavioral health workforce. Current CEMIG grantees include: White Earth Nation, Minnesota Indian Women's Resource Center, American Indian Family Center, and Mash-ka-wisen Treatment Center.

Impacts to Counties:
Workforce shortages, especially LADC workforce shortages, are an ever-present issue faced by counties who may wish to administer SUD comprehensive assessments. In addition, counties are seeking ways to free-up hospital emergency department and other beds and transition people to more therapeutic settings. Counties have historically advocated for funding to support ongoing funding for the Transition to Community initiative. This proposal will positively impact workforce and hospital decompression efforts.

IT Costs
There are no IT Systems impacts associated with this proposal.

Results:
DHS is working with a contracted vendor to assess the impact of CEMIG grant outcomes. The evaluation encompasses the broad program goals of: cultural responsiveness/competency, evidence of impact on health disparities, culturally-specific services, workforce development, and the professional capacity of cultural providers. The evaluation seems to respond to the following research questions:

- To what extent did the programs successfully engage representatives from cultural and ethnic communities in order to advance health equity?
- To what extent did the programs provide quality culturally competent and responsive supports and services to cultural communities?
- What appear to be the key variables (related to the interventions and to the population groups) associated with success? Where do opportunities and gaps remain?
- How many qualified mental health providers, LADCs and Peer Specialists from cultural and ethnic minorities or underserved communities can be attributed to the workforce development component of the initiative?

The evaluation is engaging providers to develop an initiative-wide learning plan that will include the key evaluation questions. The grant initiative has established a Community of Practice that will include a focus on service provision and on evaluation capacity building. The evaluation will also include annual focus groups with providers, community or client-level surveys, and cultural community key informant interviews. The monitoring and evaluation also includes quarterly service data collection on services provided, demographic summaries, and communities engaged through outreach efforts.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			17,608	17,696	35,304	17,696	17,696	35,392
HCAF								
Federal TANF								
Other Fund								
Total All Funds			17,608	17,696	35,304	17,696	17,696	35,392
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	57	CEMIG grants - Adult	5,000	5,000	10,000	5,000	5.000	10,000
GF	58	CEMIG grants - Children	5,000	5,000	10,000	5,000	5,000	10,000
GF	57	Provider Supervision grants	5,000	5,000	10,000	5,000	5,000	10,000
GF	15	BHDH FTE- CEMIG admin - 2 FTEs	277	322	599	322	322	644
GF	58	Startup Funding	1,000	1,000	2,000	1,000	1,000	2,000
GF	58	PRTF – Children's Intensive Service Reform	1,050	1,050	2,100	1,050	1,050	2,100
GF	15	BHDH Admin – PRTF 1 FTE	133	153	286	153	153	306
GF	11	Operations – PRTF 1 FTE	133	153	286	153	153	306
GF	15	BHDH FTE- Provider grants 2 FTEs	277	322	599	322	322	644
GF	REV1	FFP @ 32%	(262)	(304)	(566)	(304)	(304)	(608)
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
			6	6		6	6	

Statutory Change(s):

Session law

Change Item Title: Reforming Behavioral Health Peer Supports

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	2,332	4,760	4,518	4,520
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	2,332	4,760	4,518	4,520
FTEs	**2**	**3**	**3**	**3**

Recommendation:

The Governor recommends investing $7 million in fiscal years 2024-2025 and $9 million in fiscal years 2026-2027 to increase access to MA peer services and recovery community organization (RCO) services. This proposal does the following:

1. Requires accreditation through a state-based credentialing entity, the Association for Recovery Community Organizations (ARCO), or the Council on Accreditation of Peer Recovery Support (CAPRSS) in order for an RCO to become and MA eligible vendor of peer recovery services;
2. Codifies and requires RCOs that provide MA peer recovery services to meet best practices;
3. Integrates standards and training for recovery peers and mental health peers;
4. Establishes ongoing funding for peer training;
5. Expands MA vendor eligibility for peer recovery services to counties;
6. Adds base funding for RCO grants to pay for community-based recovery services that are not MA eligible; and
7. Provides start-up grant funding for culturally-specific Recovery Community Organizations.

Rationale/Background:

Humans are hard wired for connection. Feeling soothed when in the presence of close friends and experiencing distress when left behind are basic features of the human experience. Neuroscience confirms that when social bonds are threatened or severed, people can experience adverse health and educational impacts.[1] Furthermore, neuroscientific studies confirm that social pain is analogous to physical pain.[2] Rejection, isolation, and loss quite literally hurt us. Our brains formulate an expansive sense of self that includes a constant feedback loop integrating values held by others with our own, promoting social harmony. However, western cultural norms that emphasize individualism create and reinforce sociopolitical systems that can have the effect of disrupting social connections or failing to foster them.

Even in the absence of informal community supports, behavioral health care policy has the power to help reshape communities to create social connections and strengthen overall sense of belonging, leading to better health and

[1] *Alleviating Social Pain: A Double-Blind, Randomized, Placebo-Controlled Trial of Forgiveness and Acetaminophen*. Slavich, George, et al. Annals of Behavioral Medicine, Volume 53, Issue 12. (2019). *Social: Why Our Brains Are Wired to Connect*. Lieberman, Matthew. Crown Publishers. New York. (2013).

[2] *Does Rejection Hurt? An fMRI Study of Social Exclusion*. Eisenberger, Naomi, et al. Science 302, 290 (2003). Interaction between Social pain and Physical Pain. Zhang, Ming et al. Tsingua University Press, Volume 5, Issue 4. (2020).

wellbeing outcomes. Behavioral health experts, including the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare and Medicaid Services (CMS), and the American Society of Addiction Medicine (ASAM) have consistently supported the use and expansion of what are known as "peer supports." Peer support workers are people with lived experience in the mental health or substance use disorder (SUD) recovery process. They help others experiencing similar situations to become and stay engaged and to reduce the likelihood of relapse through shared understanding, respect, and mutual empowerment. Peer support services extend the reach of treatment beyond the clinical setting into the everyday environment to support successful, sustained recovery. Peer support services serve a unique function in the continuum of behavioral health services that dissolve power hierarchies that inevitably exist in clinical relationships, so that people can feel safe and supported in sharing all aspects of their recovery journeys.

Minnesota has three Medical Assistance (MA) peer services: mental health peer specialists, recovery peers, and family peers. This proposal includes modifications for mental health peer specialists and recovery peers. Since these MA benefits were developed and implemented at different times, they have varying training, certification, and service standards requirements. This proposal also includes funding for training of all peer services to attract and retain more peers in the workforce.

MA Peer Recovery Services (PRS) and Recovery Community Organizations (RCOs)

Peer recovery services activate people with lived experience in recovery to support others experiencing SUDs by offering informational, empathetic, and emotional social supports. Recovery communities have long utilized peer networks. In Minnesota, recovery communities began to formalize peer networks when the first Recovery Community Organization (RCO) was established in 2010.

At the Governor's recommendation and as part of a comprehensive SUD reform package, the 2017 Legislature authorized the creation of an MA peer recovery benefit and funding under MA and the Behavioral Health Fund (BHF). CMS approved the new MA benefit which was implemented in 2018. Peer recovery support services are defined in statute as one-to-one by an individual in recovery qualified according to section 245G.11, subdivision 8. Peer support services include education; advocacy; mentoring through self-disclosure of personal recovery experiences; attending recovery and other support groups with a client; accompanying the client to appointments that support recovery; assistance accessing resources to obtain housing, employment, education, and advocacy services; and nonclinical recovery support to assist the transition from treatment into the recovery community. *See Minn. Stat. §245G.07, subdivision 2, clause 8*.

Qualifications for peer recovery services are specified in Minn. Stat. §245G.11, subdivision 8. They require that peers (1) have a high school diploma or its equivalent; (2) have at least one year in recovery; (3) are credentialed by the Minnesota Certification Board, the Upper Midwest Indian Council on Addictive Disorders, or the National Association for Alcoholism and Drug Abuse Counselors or a tribal nation; and (4) receive ongoing supervision by an alcohol and drug counselor.

Prior to MA peer recovery services, RCOs were funded through various, sometimes grassroots, mechanisms including grants administered by the DHS. While individual MA recovery peers are certified as noted above, it would not be practicable for individual peers to bill MA themselves. Instead, the Legislature approved a process whereby certain entities would be certified as eligible MA vendors to bill for PRS. PRS can be provided in any location, meeting people where they're at; however, eligible MA vendors are SUD treatment programs and RCOs that meet certification requirements identified by the DHS.

There is only one accrediting body for RCOs in the US: the Council on Accreditation of Peer Recovery Support Services (CAPRSS). Both CAPRSS and the Association of Recovery Community Organizations (ARCO) are part of Faces and Voices of Recovery, a national organization based out of Washington D.C. CAPRSS is an arm of ARCO and in order for an organization to become accredited as an RCO by CAPRSS, they must also be a member of ARCO. In Minnesota, RCOs are not required to obtain licensure to enroll as an eligible Minnesota Health Care

Programs provider for PRS, but they must meet fidelity standards through membership in the Association of Recovery Community Organizations (ARCO) or be accredited by the Council on Accreditation of Peer Recovery Support Services (CAPRSS). If ARCO membership or CAPRSS accreditation is denied, then an RCO may request reconsideration directly from the Commissioner on whether it meets the fidelity standards.

Minnesota has one of the fastest growing RCO community in the nation. There are currently 18 RCOs certified to provide PRS and many SUD treatment programs that employ PRS.

In 2022, the Minnesota Management and Budget Impact Evaluation Unit, conducted an evaluation of MA reimbursable PRS. The evaluation sought to examine relevant outcomes drawing on a large data set of medical claims and treatment records. Data was used to determine whether PRS changed the likelihood that the person was:

- Diagnosed with poisoning by alcohol and/or several common drugs of abuse;
- Died of any cause;
- Was admitted to inpatient treatment;
- Successfully completed outpatient treatment;
- Received medical care in a physician's office visit;
- Experienced housing instability; or
- Had a screened-in child maltreatment report.

The evaluation found that overall, PRS had a small impact on the use of health care services and no measured impact on more discrete measures of wellbeing. PRS participants had a higher probability of completing outpatient treatment and visiting a physician's office and a lower probability of having a screened-in child maltreatment report. The evaluation did not find statistically significant differences in the likelihood of non-fatal overdose, mortality, inpatient treatment admission, or housing instability for PRS participants, relative to similarly situated comparison populations. Assessed outcomes for people with more sustained participation in PRS, were found to have similar impacts on outpatient treatment completion and physician office visits, as well as a one-time reduction in the likelihood of non-fatal overdose. These findings were largely consistent with prior national research.

While PRS participants were more likely to complete outpatient treatment and health care services, MMB's evaluation explored why the impact was not more widespread. The first potential explanation was that participants did not sustain PRS long enough for the service to have its intended effect. This may limit the extent to which peers could connect and form therapeutic alliances, which practitioners agree—and research shows—is key to success for PRS. Many organizations are new to PRS and may be developing operations and learning how to best match people to peers. Stakeholders noted that the peer workforce is relatively small and that many treatment providers and RCOs may have trouble finding a trained peer that may be good match. This may lead to peers and people not developing the strong bonds necessary for PRS to be effective. Additionally, stakeholders indicated that organizations billing for PRS may not have had the financial resources to properly support their peer workforce. MA reimbursement only covers costs during the period when peers actively work with patients, leaving providers to cover the other costs of employing, supporting, mentoring, and otherwise retaining peers. This could mean that providers only have the resources to hire a small number of peers to work with their patients, and peers do not have the capacity to adequately connect with all of them, or providers cannot provide the necessary training and mentoring that peers need to deliver the best version of the program.

MMB also noted there may also be considerable variation in the content and quality of peer training programs. While all peers must be certified and complete training with an approved vendor following an approved curriculum, there are numerous organizations and curricula supported by the state's certifying body. This means that peers across, and potentially within, organizations may use different approaches. Multiple stakeholders echoed these concerns and pointed to the need for a more cohesive system of training and standardized curriculum.

Finally, MMB noted that developing a new statewide system of benefits that integrates well-established principles and practices and spans organizational models takes years of intentional investment and planning. It will likely take more time and resources to maximize the benefits of PRS. The recommendations in this proposal build on the MMB PRS evaluation findings and learnings acquired since DHS implemented PRS.

Certified Peer Specialists (CPS)

Certified Peer Specialists (CPS) are individuals with a lived experience of mental illness who are willing to help others in similar situations. Certified peer specialists offer support and hope to individuals with mental illness by sharing their story and helping them to discover their strengths. Certified peer specialists assist the people they serve by helping break down barriers to community resources and provide encouragement for involvement in community activities that support their goals and interests. The 2007 Legislature passed legislation (See Minn. Stat. §256B.0615) to cover Certified Peers Specialists under Medical Assistance for an array of rehabilitative mental health services. These services include Assertive Community Treatment Services (ACT), Adult Rehabilitative Mental Health Services (ARMHS), Intensive Residential Treatment Services (IRTS), and Crisis Stabilization services. In 2014, CPSs were added to mobile crisis teams. In 2007, the formally named, Adult Mental Health Division reviewed curriculums and chose Recovery Opportunity Center's Peer Employment Training (PET) as the approved training curriculum for Certified Peer Specialists in Minnesota. Currently this is the only approved training for mental health peers.

Cross-walk of requirements for Certified Peer Specialists (Mental Health) and Recovery Peers (Substance Use Disorders)

	Certified Peer Specialists	Recovery Peers
Age Requirement	None	Must be 18
Education	No degree requirement	Proof of diploma or GED
Length of Recovery	Nothing in statute about length of recovery	Must have a minimum of 1 year in recovery from substance use disorder
Training	Successfully complete approved training (only 1)	Successfully complete curriculum approved by UMICAD, MN Certification Board or NAADAC (the Association for Addiction Professionals
Group services	Can be provided in groups	Cannot be provided in groups
Continuing Education Requirements	30 hours every two years but no collection or review process	15 hours every year and the certifying body collects and reviews
Testing	Must take a test and are certified after taking the training	Must take a test through the MN Certification Board
Certification Board	Has no certification board to collect CEU's or investigate complaints	Certified by a board that reviews CEU's and can investigate complaints
Tracking	No tracking system identifies current certified peers	MN Certification Board, UMICAD and NAADAC have established tracking system.

Proposal:

This proposal builds on knowledge acquired through the implementation of MA peer services, as well as research conducted by MMB and input from stakeholders to further refine peer services and improve outcomes for the thousands of Minnesotans who are impacted by mental health conditions and substance use disorders.

This proposal does the following:

1. **Best-practice standards for non-profit organizations seeking to become an RCO.**

Currently, there are no standards or best practices in law to guide RCOs in Minnesota. It is necessary to codify standards and best practices to ensure fidelity to well-established organizational models and to ensure services are high-quality, ethical, and culturally responsive. RCO's seeking to be eligible vendors for MA peer recovery services must be accredited by a state-based RCO identified by the commissioner, ARCO, or CAPRSS. They must meet codified best practice standards in order to be an eligible MA vendor of peer recovery services. This proposal also specifies appeals rights for RCOs that were denied enrollment as an eligible MA vendor.

This provision will codify RCO best practices, require that credentialed RCOs must:

- Be non-profit organizations;
- Be led and governed by the recovery community (at least 50% of board members are persons in recovery, at least 50% of their staff identify as persons in recovery, receive input from the recovery community);
- Be a grassroots organization, demonstrated by community engagement, volunteering, and advocacy,
- Include a participatory process, primary focus is Recovery from Substance Use Disorder and/or Mental Illness;
- Provide Peer Recovery Support Services as either a billable or non-billable service regardless of ability to pay;
- Accept and promote all pathways to recovery for each individual requesting services;
- Have established diversity, equity, and inclusion policies;
- Promote recovery friendly language throughout policies and procedures; and
- Post code of ethics and grievance policies for staff and recoverees.

Two FTE's are needed to implement this change. One MAPE 17L FTE starting in FY 2024 will be needed to implement this work and will be responsible for stakeholder engagement and implementing necessary legislative changes. In addition, this individual would be responsible to determine whether entities are eligible vendors as Recovery Community Organizations. The position would collaborate with internal and external entities and ensure that programs are in compliance with Recovery Community Organizational standards. The other position, a MAPE 14L FTE will start in FY 2025 to assist with this process, provide training and also provide grant management services as needed.

2. **Integrate standards and training for recovery peers and mental health peers.**

As noted in the background section, certified peer specialists and recovery peer services have varying qualifications, training, and ongoing educational requirements. This provision will standardize requirements, integrate training, and require the Minnesota Certification board to also certify peer specialists using an integrated mental health and SUD curriculum and test. The changes will allow for a peer with either a mental health diagnosis or substance use disorder to receive training on the critical components of being a peer and to take one test that certifies them as an integrated peer. At this time, two separate tests are required. The integrated training would be a train the trainer model, which would allow other individuals or organizations to provide necessary training allowing for consistency in the training being provided as well as broadening access to the training.

This provision includes $100K of funding per year, ongoing for the Minnesota Certification Board to implement these changes. An additional $43K is appropriated in FY 2024 for training needs.

3. Increased funding for training the mental health, recovery, and family peer workforce.

This provision includes additional funding to allow for the expansion of the peer workforce through training and development of all peers providing services to those impacted by mental health and substance use disorders. The funding will support an integrated peer recovery training for mental health peer specialists and recovery peers.

Currently, family peer training is being provided by Behavioral Health Division staff. This proposal will allow training and support to be provided by an external advocacy organization. Funding for Family peer training would include administration of a grant to revise and amend the current training and to provide this training 4 times a year at a minimal cost to participants.

- One-time funding in FY2025 of $250,000 for Integrated Peer Training.
- Workforce Development and Peer Training funding of $1,000,000 annually starting in FY2024.

4. Expansion of MA vendor eligibility for peer recovery services to counties.

Counties are not currently eligible vendors of MA peer services. This provision will allow counties to become eligible vendors to expand access to peer services, particularly for populations that are involved in the criminal justice system. This provision will clarify that Tribal Nations are also eligible vendors, however Tribes are currently able to provide and bill for the peer services using federally approved Indian Health Services encounter rates. For this portion of the proposal, the total amount of state Medical assistance cost is $170,000 in the FY 2024-2025 biennium and $270,000 in the FY 2026-27 biennium. In addition, the MAPE 17L FTE noted above under #1 would determine MA vendor eligibility for peer recovery services.

5. Adds base funding for RCO grants to pay for community-based recovery services that are not MA eligible.

The 2021 Legislature authorized temporary RCO grants to provide funding for costs related to community-based peer recovery support services that are not otherwise eligible for MA recovery peer services under Minn. Stat. §254B.05. In response to the MMB evaluation on PRS and in order to create ongoing sustainability and enhancement of more diverse peer matching services, this proposal extends the funding which is slated to end March 31, 2024 into the ongoing base funding for RCOs. The original annual appropriation of $2 million started in FY 2022 and ends in FY 2024. The full $2 million appropriation is needed starting in FY 2025.

6. Start- up grants for culturally-specific recovery community organizations

This provision provides start-up grant funding for culturally-specific recovery community organizations (RCO's) starting in FY 2024. The total amount available for these organizations is $1 million a year. The funding will be used to build capacity and improve access to SUD treatment for Black, Indigenous, and People of Color to access culturally-specific peer services. Research has documented that Black and Native people are less likely to engage in treatment and services for substance use disorder. Studies and research identify one of the barriers to these populations accessing services is that the majority of the population feels there is a mismatch between the limited treatment and service options and their own cultural beliefs and preferences. Urban American Indian populations in Minnesota have voiced a need for more culturally-specific peers to connect with people who are struggling with substance use disorder, especially opioid use disorder, and to support them in accessing resources, treatment, instilling hope, and connections with the recovery community. In addition, culturally specific RCOs could act as hubs helping to connect other entities supporting people with SUDs including: street outreach teams, housing providers, withdrawal management programs, and hospitals. One MAPE 17 FTE will be needed for administering this new grant program and developing the program.

Impact on Children and Families:

This proposal would improve access to RCO's that serve families and youth to achieve credentialing in a more streamlined way without barriers. It will allow for engagement for individuals in contemplative stage of change. Mental health and substance use disorders impacts the entire family system and is sometimes referred to as a family disease. Currently Minnesota has one Recovery Community Organization that serves families impacted by substance use and mental health disorders. This proposal will allow for expansion of these services by eliminating barriers to becoming recognized as an RCO. This proposal also opens the door to younger individuals becoming peer specialists and working with individuals who are seeking services that might be closer to them in age. For example, an 18 year old seeking services through a Recovery Community Organization would be able to work with a peer who is closer to their age and possible experience. Also, the more accessible peers with co-occurring disorders are for individuals the more likely the individuals will receive more holistic support and receive information on resources which would impact positively for families.

Depending on how peer support services may be utilized within the county or tribe, there is an opportunity for significant positive impact on children and families. For example, if a mother or father involved with child protection due to substance use can connect with a peer to help support them by sharing their own experience and assisting with navigating the system it may have a better response than if it is a case manager or clinician.

Equity and Inclusion:

This budget proposal expand access to RCO's that serve all Minnesotans and credential RCOs in a more streamlined fashion. Currently, in Minnesota there are 18 Recovery Community Organizations statewide. All of these RCO's serve the community in which they are located, and some serve targeted communities. Between 7/1/2014 and 10/18/2022, 23% of people served by RCOs identified as a person of color and 68% identified as white. This proposal would help eliminate inequities for people of color, people with disabilities, people in the LGBTQ community and other protected classes.

In the MMB's 2022 evaluation, it was noted there were few differences across race, gender, and ethnicity in the data collected. However, of those surveyed, 16% were more likely to have a physician's office visit. In addition, over the course of the 12-month study over 60% were more likely to complete outpatient treatment if they have had an encounter with a peer. By providing support and structure for the Recovery Community Organizations providing peer support services, there will be a greater ability to increase these numbers. It is also important to compare this with the cultural assessment tool used by ACET Inc. for current RCO grantees. In the report produced by ACET, of the RCO's surveyed, it was reported that they continue to seek support as organizations to do on-going work for their community. They report "constantly putting out fires" as boots on the ground organizations, and despite efforts to address culturally responsive structure, they are not as far along as they would like to be. In the survey, based on the responses collected by three RCO's they reported that they had served, over 75% that identified as African American, over 50% that identified as multicultural, over 50% identified as Hispanic/Latino, American Indian, Asian American, or African. These numbers are significant in demonstrating the work that only a few RCO's are doing to address health disparities and create programs built on equity.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Tribes are already able to bill federally approved Indian Health Services encounter rates for peer services. Tribes may be eligible to apply for RCO grants. The Little Earth community is currently exploring the possibility of developing an RCO to serve community members.

Impacts to Counties:
This proposal will allow counties to enroll and bill for MA peer recovery services.

IT Costs
There are no systems impacts related to this proposal.

Results:
DHS will continue to evaluate peer services and services provided using RCO grant funds. Peer programs will be encouraged to use assessment tools to measure participant experience and outcomes. One common tool used to evaluate mental health and substance use disorder peer services is the Recovery Assessment Scale (RAS). The full RAS takes about 20 minutes, measuring 41 items. A shorter instrument is also available, measuring 24 items. The tool may be used for both adults and adolescents. Content measured includes: self-confidence; hope; willingness to ask for help; goal orientation; reliance on others; and self-identity. Recovery domains measured include: relapse resiliency; values essential to recovery; self-management of disorder; motivation; self-awareness; hope, engagement in services; and interpersonal relationships.

DHS will also collect the follow data to measure proposal impact:

- Baseline and ongoing peer retention rates;
- Rate of peer vacancies, demand for peer services, and increases in demand (waitlists);
- Workplace and supervisory satisfaction of peers;
- Peer survey results from training and ongoing education.

MMB's Impact Evaluation unit noted that more data is needed to study the qualitative and quantitative impact of peer recovery services. They also noted it may be appropriate to reevaluate the PRS program when reforms have had time to take foot and when the program is better resourced. Reevaluation should minimally include the following measures of impact:

- was diagnosed with poisoning by alcohol and/or several common drugs of abuse;
- died of any cause;
- was admitted to inpatient treatment;
- successfully completed outpatient treatment;
- received medical care in a physician's office visit;
- experienced housing instability; or
- had a screened-in child maltreatment report.

Fiscal Impact

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			2,332	4,760	7,092	4,518	4,520	9,038
HCAF								
Federal TANF								
Other Fund								
Total All Funds			2,332	4,760	7,092	4,518	4,520	9,038
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	59	Recovery Community Organizations- grants	-	2,000	2,000	2,000	2,000	4,000
GF	15	MN Certification Board	143	100	243	100	100	200
GF	57	BH Workforce grants	1,000	1,000	2,000	1,000	1,000	2,000
GF	15	Integrated Peer Training	-	250	250	-	-	-
GF	REV1	FFP @ 32% for admin cost	(136)	(180)	(316)	(180)	(180)	(360)
GF	59	Expediting Access to BH Treatment Start Up Funding	1,000	1,000	2,000	1,000	1,000	2,000
GF	15	FTE for BHDH grant contract admin and oversight related to credentialing (2FTEs)	141	299	440	300	300	600
GF	15	FTE for admin for expediting access to BH treatment start-up funding	141	164	305	164	164	328
GF	33	Peer Services	43	127	170	134	136	270
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
			2	3		3	3	

Statutory Change(s):

256B.0615, 245G.11, 245G.07, 245F.01, 245I, 254B

Change Item Title: Sober Housing Program Regulation and Consumer Protections

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	188	219	355	287
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	188	219	355	287
FTEs	**2**	**2**	**2**	**2**

Recommendation:

The Governor recommends investments to ensure people residing in sober homes have access to person-centered, culturally-responsive, quality services that support them in their recovery journeys. This proposal invests $407,000 in FY 2024-25 and $642,000 in FY 2026-27 to establish a certification program for sober homes to ensure health and safety, consumer protections, access to prescribed medications, and staff training and policies.

Rationale/Background:

Sober housing programs are an important component of the substance use disorder (SUD) continuum of care. They have also come under scrutiny by policymakers across the nation due to serious concerns raised by community advocates, residents, and family members about a segment of unethical sober home operators and poorly managed sober homes. These concerns prompted the United States Government Accountability Office (GAO) to examine sober housing in 2018. State level policy makers in numerous other states have enacted laws designed to protect residents and improve quality across sober home providers. The Substance Abuse and Mental Health Services Administration (SAMHSA) endorsed a set of national standards as best practices for sober homes (also called “recovery residences”). These standards were created by the National Association for Recovery Residences (NARR) and create a blueprint for high quality sober homes. They are tailored to each major type of sober home.

Minnesota is one of 23 states that does not currently require sober homes to meet nationally-endorsed standards. Other states have taken a variety of approaches to oversight, ranging from no regulation to required licensure or adopting more targeted consumer protections. A more common approach taken by states in recent years is to adopt a voluntary certification process with incentives for sober homes to obtain it. Nineteen states have taken this voluntary certification approach. Six states require licensure or certification and two states have targeted consumer protection laws related to sober homes.

Sober homes share a number of essential characteristics. A core foundation of a sober homes is an environment that puts strong emphasis on peer support. Sober homes are modeled on the power of working toward recovery with other people also working toward recovery. Typically, sober homes either require or strongly encourage attendance at 12-step self-help groups such as Alcoholics Anonymous (AA). Sober homes also require compliance with house rules such as maintaining abstinence, paying rent, helping with house chores and attending house meetings. Residents usually pay their own cost and can stay in the house as long as they wish, provided they comply with house rules. Sober homes do not offer clinical treatment services as they are not intended to be clinical settings. Sober home living is intended to be a step on the way toward full independent living.

Sober homes vary in terms of the number of residents that live in the home. There is a strong value placed on having a community of people working toward recovery in the home and keeping residents in the company of each other to support the recovery process. Having a minimum of six to eight residents is common in order to achieve this purpose and sober homes can have as many as 15 residents. Many sober homes have residents share a room with one or sometimes two other residents, which helps keep cost more affordable and reduces isolation, especially for people new to recovery.

Most sober homes are private pay only. Affordability of sober homes is a major concern of residents and their family members. Many individuals who have recently participated in substance abuse treatment or are otherwise new to recovery may be unemployed given their recent substance abuse. Being able to share the cost of rent across multiple house residents keeps costs more affordable to each individual. This self-pay funding model is viewed as a strength by some because sober homes are not vulnerable to cuts in public funding. Others, however, point out that many individuals new to recovery have very few resources and need assistance in paying for their rent. Most state or local governments provide some basic oversight of sober homes if they are considered "board and lodging" settings from a health and safety standpoint. Local governments typically have zoning laws related to the number of unrelated individuals who can live in a single-family home.

The 2021 Legislature required DHS to consult with stakeholders and develop recommendations to: (1) increase access to sober housing programs; (2) promote person-centered practices and cultural responsiveness in sober housing programs; (3) identify potential oversight of sober housing programs; and (4) provide consumer protections for individuals in sober housing programs with substance use disorders and co-occurring mental health conditions. DHS formed a workgroup including the Minnesota Society for Addiction Medicine, NAMI Minnesota, Minnesota Association of Resources for Recovery and Chemical Health (MARRCH), and Minnesota Association of Sober Homes (MASH).

Proposal:

This proposal creates a certification for sober housing programs that receive state funding and voluntary certification for privately funded sober housing programs; establishes a registry of certified sober homes; codifies quality and consumer protection standards; ensures integrated behavioral health capacity; and requires that people have access to all prescribed medications including medications for opioid use disorders.

Certified sober housing programs will be required to:

- Meet health and safety standards;
- Establish intake and admission procedures;
- Follow resident bill of rights;
- Establish policies to address mental health and health emergencies to prevent a person from harming themselves or others;
- Establish policies on staff qualifications and prohibition against fraternization;
- Establish policies on storing and providing access to all prescribed medications, including medications for opioid use disorders;
- Ensure staff training and availability of naloxone on-site;
- Establish discharge procedures, including involuntary discharge procedures that ensure proper notice and ensure safety;
- Maintain a policy on referrals to substance use disorder services, mental health services, and peer support services; and
- Ensure staff training on mental health crises, de-escalation, person-centered planning, crisis planning, and culturally-responsive services.

During FY 2024 and FY 2025, two FTEs (a MAPE 15 and a MAPE 17) will be needed to start the planning phase of this proposal. The staff will initially collect various data points including the number of sober homes with the

number of beds in Minnesota, funding sources, providers, and demographics of people staying in sober homes. This information is needed to determine the scope of the program and to plan adequately. In addition, staff will need to meet with stakeholders and providers to formalize the process and determine how complaints and possible decertification will be handled. DHS staff will also develop an RFP for a contract of $200,000 for FY 2026. This contractor will assist in formalizing the certification standards. Before the certification program is implemented, DHS will also need to develop a training program for providers. In addition, once the program is implemented, it is expected that the staff will need to make site visits as well.

The actual certification process is expected to be implemented in FY 2026 and then an initial evaluation of the certification process will be needed in FY 2027 for $100,000. The evaluation funding will be available after FY 2027 as it will be expected that evaluations will be needed on an ongoing basis to make further recommendations on potential modifications to the regulatory structure and what agency/divisions will carry out regulatory functions.

Impact on Children and Families:

In the context of a family unit, individual decisions impact the whole family. When one family member struggles with substance use disorder, the condition can negatively affect all members of the family system. Family members may experience a state of heightened stress and anxiety, as well as feelings of guilt, confusion, anger, hopelessness, depression, physical health impairments, and financial problems. These secondary impacts can lead to family conflict and dysfunction. Children are particularly vulnerable to adverse impacts when a family member struggles with substance use issues, putting them at risk of depression, anxiety, low self-esteem, impaired future relationships, increased likelihood of abusing substances, and reduced capacity to focus and learn. When children have a parent or caregiver that experiences SUD, roles often reverse, where the child begins to take on caregiving roles. This can lead to harmful stress levels for the child and set them up for difficulty setting healthy boundaries in future relationships.

As family members cope and attempt to control addictive behaviors, new patterns form. Families may struggle with negative communication patterns, lack of and inappropriate boundaries, misguided expectations, and stress levels that lead to unhealthy patterns of self-medication. Two of the more serious maladaptive patterns to develop in the face of family addiction are codependency and enabling. Due to the inconsistency and unreliability of someone who is actively struggling with a SUD, family relationships often deteriorate as disagreements and differences in coping skills drive people apart. In addition, families may develop stigmas due to deep rooted shame and resentment. Stigma can hinder people accessing treatment and lead to isolation and discrimination. The sober homes workgroup report found that many Somalis who struggle with SUD feel shame and face isolation. Parents are sometimes not aware of substance use disorders and may be more likely to attribute their child's death to a heart attack rather than to acknowledge an overdose.

Safe sober housing programs can support the healing and recovery of individuals with SUDs as well as the whole family. Sometimes people find sober housing options through community or treatment program referrals and sometimes family members may find programs for their loved ones who are struggling or looking for housing following treatment. Creating intentional space for family members to reestablish healthy boundaries and heal both individually or through family therapy can be an indicator of successful long-term recovery.

Equity and Inclusion:

Sober housing is a need across various culturally diverse communities as well as across urban and rural parts of Minnesota. Stakeholders lament the lack of sober housing generally as well as for specific cultural communities, such as for East Africans or Southeast Asians. While individual preferences for culturally specific housing vary, it would be helpful to have sober housing for specific cultural groups as an option for those who would feel most supported in these environments. Stakeholders emphasized how helpful it would be to have homes that honored cultural traditions, made space and time for prayer, had familiar meals, and where other residents spoke a similar language. Families from some communities are sometimes reluctant to acknowledge or recognize substance use

among community members, which can create shame and isolation for community members who are using substances or trying to recover from substance use.

African American and American Indian populations are dying from drug overdose deaths in Minnesota at unequal rates compared to whites. American Indians are seven times more likely to die from a drug overdose as whites and African Americans are twice as likely to die from a drug overdose as whites. Urban American Indian communities, as well as Tribal Nations have indicated the need for additional culturally specific sober housing programs. Studies have shown positive results from tribally specific housing programs, noting that the communal model aligns with Native cultural identities and traditions that value democratic structures, shared decision making, group accountability and traditional healing practices.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes

☒No

Impacts to Counties:

Counties may benefit from better protections for people in housing settings as regulations could reduce hospitalizations, detox admissions, local correctional involvement, and emergency shelter uses.

IT Costs

There are no systems costs for this proposal.

Results:

- Sober homes meet standards and are approved for certification.
- Sober homes do not discriminate against people who take medications for opioid use disorder (MOUD)
- Increase in culturally specific sober homes.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			188	219	407	355	287	642
HCAF								
Federal TANF								
Other Fund								
Total All Funds			188	219	407	355	287	642
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	15	Development of Standards - Contract	0	0	0	200	0	200
GF	15	Evaluation of Outcomes - Contract	0	0	0	0	100	100
GF	15	Certification Oversight – 2 FTE	277	322	599	322	322	644
GF	REV2	FFP @ 32%	(89)	(103)	(192)	(167)	(135)	(302)
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
			2	2		2	2	

Statutory Change(s):

Minn.Stat. §254B

Change Item Title: Medical Assistance Substance Use Disorder Continuum

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	1,522	1,684	1,566	1,584
Revenues	0	0	0	0
Other Funds				
Expenditures	0	[400]	[400]	[400]
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	1,522	2,084	1,966	1,984
FTEs	**4**	**4**	**4**	**4**

Recommendation:

The Governor recommends reforms and innovations to improve equitable outcomes for people experiencing opioid use disorders (OUDs) and other substance use disorders. This proposal has an overall fiscal impact of $3.606 million in FY 2024-25 and $3.950 million in FY 2026-27.

This proposal includes the following provisions:

1) Modifies Opioid Treatment Program (OTP) rates to ensure payment integrity and person-centered care models;
2) Establishes funding for a new Project ECHO hub focused on supporting high quality care in OTPs;
3) Administrative funding to study MA demonstrations for traditional healing, behavioral health services in jails and prisons, and contingency management; and
4) Start-up funding for withdrawal management programs.

This proposal increases direct appropriations out of the Opiate Epidemic Response Fund. When direct appropriations in the fund increase, statutory appropriations outlined in M.S. 256.043 for social service initiative projects and grants awarded by OERAC are adjusted accordingly.

Rationale/Background:

Treating Opioid Use Disorders

Research confirms that a combination of medication and therapy can successfully treat opioid use disorders and help people sustain recovery. Although reliance on medication alone is not uncommon, a combination of psychosocial treatment and medication generally is recommended for the treatment of OUD. While Opioid Treatment Programs are expected to provide this combined treatment, the quality of care varies considerably among programs. At least one OTP program has been closed due to quality concerns, and anecdotal reports about others reveal that the quality of care provided by OTPs varies considerably.

Reimbursement for MOUD delivered through OTPs is under a single daily bundled rate to the OTP. The OTP bills using two codes that distinguish between treatment with methadone and treatment with all other types of MAT medications (buprenorphine, naltrexone, or suboxone, the last of which is a combination of buprenorphine and naloxone). Modifiers are used to describe the intensity of weekly clinical services and the SUD rate enhancements available to OTP. The four current code/modifier combinations for the OTP per diem billing include the cost of medication and all treatment services. Treatment services include group therapy, individual therapy, a comprehensive assessment, treatment coordination, and peer recovery support. At a minimum, to bill for any of the code/modifier combinations that don't include 9 or more hours of clinical services, only the medication is

required to be rendered. Opioid treatment programs must also follow other requirements such as frequency of assessments and other services.

Recently, the Office of Legislative Auditor has questioned whether the Department of Human Services (DHS) has the authority to reimburse non-tribal OTP per diem payments for take-home doses of medication that patients self-administer on days in which they receive no other services.

Since 2016, Minnesota has distributed a significant amount of funding in federal opioid grants. Project ECHO is a proven, evidence-based telementoring program that DHS has deployed to expand capacity for treating OUD in primary care settings. ECHOs consist of a "hub" where specialists work in an interdisciplinary team and "spokes" that connect with other providers through videoconferences for case-based learning. The model mimics adult learning methods employed in clinical residency programs. This interactive arrangement allows for learning and guided practice throughout the state. Both Minnesota and national data reveal that participants find the ECHO learning process engaging, productive, and convenient.

ECHO will provide OTPs a meaningful method to address quality concerns and make full use of the reimbursement opportunities provided by the new billing approach. An ECHO hub, comprising a multidisciplinary team from a high-performing OTP, will reach out to the state's other OTPs to provide a supportive, mutual learning environment. One hub is sufficient to reach all of the OTPs in the state, along with any other treatment partners who wish to be included.

Minnesota's OTPs, which under federal law are the only clinics that can be licensed to prescribe methadone to OUD patients, have an uneven quality history. At least one OTP program has been closed due to quality concerns, and anecdotal reports about others reveal that the quality of care provided by OTPs varies considerably. OTP care is inconsistent across providers. The primary approach to addressing these quality gaps will be the reimbursement reforms contained in the companion OTP billing proposal.

Increasing access to behavioral health care for justice involved populations

Minnesota's Medical Assistance behavioral health service continuum does not cover populations that are incarcerated. The Medicaid inmate exclusion policy limits Medicaid reimbursement for incarcerated individuals to inpatient care at approved settings, such as hospitals. This policy has resulted in states terminating or suspending benefits for people who receive care through Medicaid, even if they are incarcerated for a short period of time. In Minnesota, coverage is suspended during incarceration, but if a person's annual MA renewal is scheduled to occur when they are incarcerated, they must reestablish coverage post-release.

Once incarcerated, the individual's health care becomes the responsibility of state and local governments in prisons and jails. Shifting between two systems of health care causes people to become disconnected from treatment, which leads to worsening overall health. For people with mental health conditions and substance use disorders, lack of inconsistent health care coverage has grave impacts. Recent data confirms that drug overdose is now a leading cause of death among formerly incarcerated individuals; recently released prisoners and jail inmates are up to forty times more likely to die of an opioid overdose than the general population. In Minnesota between 2010 and 2019, drug overdoses accounted for one in three deaths occurring within one year of release from the Department of Correction— with 20 percent of those deaths occurring in just the first two weeks of release.[1]

Some states are seeking Section 1115 waiver authority to partially waive the inmate exclusion and provide Medicaid coverage pre-release to certain groups of incarcerated individuals (Figure 1). Section 1115 waivers allow states to test new approaches in Medicaid that differ from federal rules if they promote the objectives of the

[1] Treating Opioid use Disorder for Criminal Justice Involved Individuals, Minnesota Management and Budget

Medicaid program. In addition to waiving the inmate exclusion, states are also using 1115 waivers to provide MA coverage of traditional health practices and contingency management.

Traditional Healing Practices
While conventional behavioral health programs have not yielded strong outcomes for American Indian communities, traditional healing, a multi-generational, multidisciplinary approach to mental health and substance use disorder treatment, has been successful. Minnesota currently provides grant funds to tribal nations and urban American Indian organizations to pay for traditional healing. American Indian traditional healing is identified by the National Institutes of Health as a whole medical system that encompasses a range of holistic treatments used by indigenous healers for a multitude of acute and chronic conditions or to promote health and wellbeing.

For thousands of years, traditional indigenous medicine have been used to promote health and wellbeing for millions of Native people who inhabited this continent. Native diets, ceremonies, and the use of native plants for healing have been used to promote health. Younger generations of Native people have been separated from these traditions through systematic federal policies that forcibly removed children from their families, stripped nations of their land, and criminalized the practice of native religions. Actions such as these, sanctioned by the United States government, as well as ongoing settler colonialism bias have resulted in extreme health disparities for Native populations. For example, Minnesota has the worse opioid overdose disparities in the nation, with Native Minnesotans bring 10 times as likely as white people to die from opioid overdose.

Contingency Management
Contingency management (CM) refers to a type of behavioral therapy in which individuals are rewarded for evidence of positive behavioral change. These interventions have been widely evaluated in the context of substance use disorder treatment. They most often involve provision of monetary-based reinforces for submission of negative toxicology tests. CM is the only treatment that has demonstrated robust outcomes for individuals living with stimulant use disorder, including reduction or cessation of drug use and longer retention in treatment. California is the only state in the country to receive federal approval of CM as a benefit in their Medicaid program, under the authority of an 1115 demonstration waiver. Psychostimulant-involved drug (such as methamphetamine) overdoses have steadily increased in Minnesota. SUD treatment admissions for methamphetamine have also been on the rise over the past decade.

Proposal:

1. ***Opioid Treatment Program (OTP) rate methodology reform***

This proposal breaks apart the current OTP daily bundle and separates the drug component from the rest of the OTP services. The proposed payment method includes a weekly drug bundle and non-medication components of MAT (e.g. substance use counseling, individual and group therapy, and toxicology testing) that are billed and paid under the same provisions as if provided separately under the OBOT method. The drug bundle payment rate is based on Medicare's weekly drug cost. The proposed rate methodology supports the full array of services an OTP is required to provide, promotes transparency and accountability, and addresses concerns related to risks associated with billing for days the patient self-administers their medication. These programmatic changes to Minnesota Health Care Programs (MHCP) are assumed to be budget neutral as discussed in the fiscal section of the proposal.

In addition, this proposal requires administrative and systems funding. The proposal includes two FTEs starting in FY 2024 to implement the initiative. These FTEs are needed to develop the policy changes while working with stakeholders, develop training and other written resources for providers and provide oversight over the new initiative. In addition, the FTE's will provide data analysis to develop codes and modifiers within the DAANES system while working with MNIT on the new application.

System changes are needed as well in DAANES, MPSE, MMIS and SQL systems. These systems changes are estimated to require 3,331 hours of work, take approximately 17 months to complete, and cost of a total of $317,493 for initial development with a state share of $195,000 in FY 2024.

2. ***Expanding Project ECHO.***

This provision requires DHS to contract with a high-performing OTP to serve as an ECHO hub. The contracted OTP would use its grant funds mostly for the hub faculty's salaries and guest speaker fees. They may also use funds as needed to purchase audiovisual and other relevant equipment needed in a distance-learning environment. The hub would be charged with establishing a multidisciplinary team comprised of addiction medicine specialist(s), addiction counseling, behavioral health, and social work. Other disciplines could include pharmacy, integrative care, nursing, paraprofessional health care workers (e.g., community health workers, peer recovery specialists), and traditional healers. The contractor would be required to include content not just on clinical and behavioral health therapy, but also on historical trauma and other topics relevant to treating the diverse patients who use OTP services.

The hub would conduct ECHO virtual "clinics" at least twice monthly and provide continuing medical education and continuing education credits for other professionals participating in the virtual clinics. This approach has been proven effective among primary care practitioners and others treating OUD in Minnesota; extending ECHO to OTPs is a natural next step. Participating spokes would be the other OTPs in the state. The grant amount would include $400,000 in FY 2025 to continue the existing funding that ends in FY 2024. The funding also includes a one year contract in FY 2024. A one-year contract of $200,000 is needed for evaluating the current data.

3. **Administrative funding to study the feasibility and requirements of a Medical Assistance demonstration waiver to allow MA payment for traditional healing practices, behavioral health services in jails and prisons, and contingency management.**

This provision includes $600,000 in FY 2024-2025 to fund a feasibility and benefit design study to prepare Minnesota to submit a strong 1115 demonstration waiver or other waivers to implement MA traditional healing practices, MA behavioral health services in jails, and an MA contingency management program. Funding will also allow DHS to engage with relevant stakeholders and experts in the design of these new, innovative MA benefits. In addition, one FTE (MAPE 17) will be needed on a permanent basis to administer the study and also work to get the waiver approved by both the state legislature and federal government. This individual will be responsible for moving forward for this waiver.

4. **Withdrawal Management Start-up Funding.**

This provision provides $1,000,000 annually in start-up and capacity building grants for withdrawal management. In FY 2024, the funding will be phased in at $500,000. Minnesota currently has nine withdrawal management settings which provide crucial services to assist individuals experiencing acute withdrawal and safely monitor their health using a medicalized, high-quality model. Withdrawal management programs also encourage people to consider treatment and help coordinate access to treatment services for willing individuals. One FTE (MAPE 17) will be needed to develop, work with providers and administer the grants.

Impact on Children and Families:

Addressing opiate use among parents and potential exposure to children would improve outcomes for children and families. Chronic opiate exposure to the unborn baby during the mother's pregnancy or upon abrupt discontinuation of opioid after birth can result in newborns showing signs of opiate withdrawal, termed Neonatal Abstinence Syndrome (NAS) or Neonatal Opiate Withdrawal Syndrome (NOWS). NOWS is characterized by a wide array of symptoms including increased irritability, hypertonia, tremors, feeding intolerance, watery stools, seizures and respiratory distress, etc.

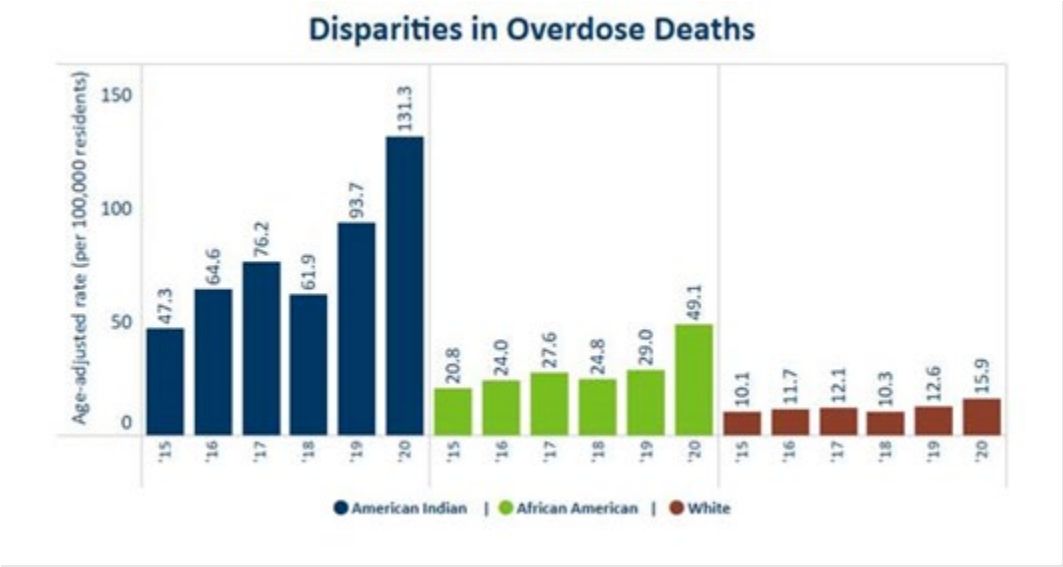
From 2010 to 2014, rates of NOWS more than doubled in Minnesota. Babies that are born with NOWS are more likely to be born preterm, have low birth weight and have inadequate or no prenatal care. It is important to remember that not all mothers of babies born with NOWS are diagnosed before birth as being dependent on

opiates, not all pregnant women dependent on opiates give birth to a NOWS baby. Therefore, opiate dependency in some percentage of pregnancies will remain unknown as there is no universal screening for substance use disorders in pregnancy.

Additionally concerning are the disparities that occur in NOWS. More than one in ten pregnancies among American Indian women have a diagnosis of opiate dependency or abuse during pregnancy. NAS occurs when newborns withdraw from opiates due to maternal opioid use during pregnancy. In Minnesota, there is an 8-fold higher rate of NAS among infants born to American Indians.

Equity and Inclusion:

There are stark disparities in prescription drug overdoses among racially and ethnically diverse populations in Minnesota. Opioids and other drugs have been especially harmful in tribal communities and communities of color in Minnesota. In 2015, American Indian Minnesotans were five times more likely to die from a drug overdose than white Minnesotans, and African American Minnesotans were two times more likely to die from a drug overdose than white Minnesotans. As of 2020, American Indian or Alaska Natives made up about 11 percent of opiate overdose deaths, compared to making up about 1 percent of Minnesota's overall population. Black or African American people made up about 21 percent of opiate deaths compared to making up about 6.5 percent of Minnesota's overall population. White people made up about 68 percent of total opiate deaths in 2020 compared to making up about 83 percent of Minnesota's population.



The urgent need to reach American Indian and African American communities is supported though numerous data sources. Although American Indians make up an estimated 1 percent of the state's population, they made up 15.8 percent of those who entered the treatment for opioid abuse during the state fiscal year 2015. American Indian communities are 8.7 times more likely to be diagnosed with maternal opiate dependency or abuse during pregnancy compared to non-Hispanic whites; infants are 7.4 times more likely to be born with neonatal abstinence syndrome (NAS) now referred to as Neonatal Opioid Withdrawal Syndrome.

African Americans made up an estimated 5.8 percent of Minnesota populations are African American (Non-Hispanic) but make up 10.1 percent of the treatment population for opioid abuse in state fiscal year 2015. In addition, the age-adjusted drug overdose mortality rate for African American/Blacks in Minnesota is the sixth highest in the U.S. (among the 38 states for which data are available). However, the age-adjusted disparity rate ratio of African Americans/Blacks relative to whites ranks first in the U.S., meaning death due to drug poisoning was two times greater among African Americans/Blacks relative to Whites.

Epidemiological data from the Minnesota Department of Health identifies populations experiencing disparities by race, geographic location (catchment area), and justice involvement. It shows that American Indians, African Americans, and individuals with justice involvement experience the highest disparities. They have the greatest need for medications for OUD; culturally responsive, evidence-based recovery services, including supportive housing; and providers and a workforce with knowledge about OUD, stimulant misuse and use disorders, and nicotine use disorder. Other targeted populations in need include individuals who are hard to reach, such as pregnant and parenting women with OUD, those experiencing homelessness with OUD, and communities of color with OUD. According to the state's Drug and Alcohol Abuse Normative Evaluation System, in 2019, opioid treatment admissions were 9,838 or 15 percent of all treatment admissions. In 2018, opioid treatment admissions were 10,278 or 16 percent of all treatment admissions.

In 2018, the drug overdose mortality rate in Minnesota was ranked eighth lowest in the nation. However, Minnesota ranked first (worst) when measuring the disparity rate ratio of drug overdose deaths among Native Americans relative to whites, and second among African Americans relative to whites. In 2019, Native Americans were seven times more likely to die from a drug overdose than whites; African Americans were two times more likely to die from a drug overdose than whites. The drug overdose mortality rate disparities in Minnesota have worsened, specifically for Native Americans. The 2019 rates were 93.7 per 100,000 residents for Native Americans; and 29 per 100,000 residents for African Americans. The rate for whites is 12.6 per 100,000 residents.

In 2018, the Department of Corrections (DOC) reported 1,300 offenders with OUD. In 2005, this number was 600. DOC has only 1,051 beds for offenders with substance use disorder (SUD) for treatment prior to release. The last Neonatal Abstinence Syndrome (NAS) study in 2014 is based on four years of combined data involving Medicaid enrollees. In Minnesota approximately 90 percent of births by American Indian women are covered by Medicaid. The percentage of births by American Indian women with a prenatal diagnosis of SUD, including opioids and stimulants, was 32.3 percent compared to 7.2 percent of all births. In 2018, the NAS/Neonatal Opioid Withdrawal Syndrome rate was 4.8 cases per 1,000 hospital births (per HCUP Fast Stats, NAS among Newborn Hospitalizations, 12-Dec-2019).

National data reveal that people of color are more likely to obtain OUD treatment from OTPs than from primary care clinics, because OTPs tend to be clustered in urban areas like the Twin Cities. It is time to attend to OTP quality of care, just as Minnesota has invested in ECHO to expand and buttress the quality of care provided by primary care throughout the metro area and Greater Minnesota.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Tribal governments may be able to integrate traditional healing into their tribally operated programs either under an MA demonstration waiver or within Minnesota's federal "Four Walls" design.

Impacts to Counties:

This proposal is not expected to have an impact to counties.

IT Costs

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll						
Professional/Technical Contracts						

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)	317,493	63,449	63,449	63,449	63,449	63,449
Total	**317,493**	**63,449**	**63,449**	**63,449**	**63,449**	**63,449**
MNIT FTEs	10.75	1	1	1	1	1
Agency FTEs						

IT work will impact SQL, DAANES, MPSE, and MMIS systems, as changes are needed to separate the current OTP daily bundled rate and establish a weekly drug bundle rate that allows for the non-medication services to be billed individually. Systems changes are estimated to require 3,207 hours of work and take approximately 17 months to complete. The total cost of the initial development is $317,493.

Results:

In 2021, Minnesota Management and Budget (MMB) found that ECHO is making a significant difference in care provided by primary care practices around the state.[1] Providers who attended one or more ECHO sessions were more likely to provide buprenorphine (one form of medication for OUD) to their patients with OUD than comparison providers at 6, 12, and 18 months after ECHO. For every 100 OUD patients that providers saw per month, ECHO providers prescribed buprenorphine for 6.5 more patients than comparison providers. Providers who attended six or more ECHO sessions had the greatest growth in prescribing Medication-Assisted Treatment, suggesting that strong participation is important for seeing benefits from ECHO. Patients who saw an ECHO-trained provider were more likely to receive buprenorphine prescriptions 6, 12, and 18 months after their initial visit with that provider (a 4.2 percentage point net increase at 18 months), relative to patients who saw a comparison provider. This program's impact is significant, with MMB staff referring to ECHO's effects as "nearly unprecedented." ECHO is supporting a robust continuum of care—prevention, early intervention, treatment, and recovery services —that mitigates the harm of opioid addiction.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			1,522	1,684	3,206	1,566	1,584	3,150
HCAF			0	0	0	0	0	0
Federal TANF			0	0	0	0	0	0
Other Fund			0	400	400	400	400	800
Total All Funds			1,522	2,084	3,606	1,966	1,984	3,950
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
OERF	59	Project Echo	0	400	400	400	400	800
GF	15	Contracted Cost for Evaluation	200	0	200	0	0	0
GF	15	BHDH Admin – 2 FTEs	283	330	613	330	330	660
GF	11	DANNES – MNIT System Cost (70% state share)	88	18	106	18	18	36
GF	11	SQL – MNIT system cost (100% state share)	57	11	68	11	11	22
GF	11	MMIS – MINT system cost (29% state share)	35	7	42	7	7	14
GF	11	MPSE – MNIT system cost (100% state share)	15	3	18	3	3	6
GF	33	OTP Rate Costs	35	61	96	79	97	176
GF	15	1115 Admin - Contract	400	200	600	0	0	0
GF	15	1115 Admin – 1 FTE	141	165	306	165	165	330
GF	59	Withdrawal management grants	500	1,000	2,000	1,000	1,000	2,000
GF	15	BHDH admin cost for Withdrawal management grants (1 FTE)	141	164	305	164	164	328
GF	REV1	FFP @ 32%	(373)	(275)	(648)	(211)	(211	(422)

Statutory Change(s):

254B, 245G

Change Item Title: Advancing Independence & Housing Stability: Improvements to Housing Stabilization Services

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	3,495	7,774	8,712	9,572
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	3,495	7,774	8,712	9,572
FTEs	**10**	**10**	**10**	**10**

Recommendation:

Effective July 1, 2023, the Governor recommends expanding housing services that support people in gaining stable, integrated housing. This investment:

- Expands the Housing Stabilization Services Medical Assistance benefit to pay for transitional moving expenses when people are moving to their own homes from provider-controlled settings;
- Adds an inflationary update to Housing Stabilization Services payment rate methodology;
- Extends state funding to Heading Home Corps housing resource navigator program;
- Sustains resources and infrastructure that make finding and understanding housing options and supports more accessible to all people; and
- Provides a cost-neutral technical change to requirements for the Home and Community Based Services (HCBS) spending plan.

The General Fund investment for this proposal is $11.269 million in FY 24-25 and $18.284 million in FY 26-27.

Rationale/Background:

Homelessness and housing instability is a crisis impacting communities across the state. According to findings from the 2018 Minnesota Homeless Study's one-night count conducted by Wilder Research, the overall number of people in Minnesota experiencing homelessness increased from 9,312 in 2015 to 10,233 in 2018, a staggering 10%. People with disabilities and with behavioral health conditions deserve choice in housing and to live independently in their own homes.

Housing Stabilization Services

Housing Stabilization Services not only helps people find housing, but also offers needed support to help people maintain independent housing. Housing Stabilization Services currently serves over 10,000 people, far exceeding the numbers predicted. It supports diverse populations. Half of the population served are from Black, Indigenous, and People of Color populations and the largest group accessing services are Black men in their middle years, a group historically underserved in Minnesota. This MA state plan service is unique and increasing access to housing services to people previously underserved. The MA rates for Housing Stabilization Services are flat and have been stagnant since they were developed in 2019. Since then, inflation has increased and the rate is not keeping pace with inflation. The 2021 Legislature authorized a temporary expansion of HSS to include an annual stipend to cover a person's moving costs, allowing people moving into new housing up to $3,000 to contribute towards the

cost of moving, deposits, furniture etc. This is a critical service to support people's successful move into more integrated settings. The funding for this provision ends in March 2024.

Section 811

Section 811 is a HUD program that allows people with disabilities to live as independently as possible in the community. Minnesota Housing, in partnership with DHS, administers the HUD Section 811 Project-based Rental Assistance Program. The program began in 2016 and received additional funding in 2020 to expand resources for rental assistance. The program targets people who are experiencing long-term homelessness or are exiting an institutional setting. People receiving Section 811 rental assistance sometimes need tenancy supports to help them maintain their housing and navigate their relationship with their landlord. People may be eligible to receive this support through Housing Stabilization Services with Medical Assistance. Section 811 Tenancy Supports helps a person while they are applying for Housing Stabilization Services and helps others who are not eligible for Housing Stabilization Services. DHS currently receives temporary funding through Moving Home Minnesota to pay for these tenancy supports.

HMIS

Minnesota's Homeless Management Information System (HMIS) is a key element in making housing connections. The system collects information from all homeless service providers throughout the state, regarding the more than 20,000 homeless beds in emergency shelters, transitional housing programs, permanent supportive housing programs, homeless prevention programs, and other programs in contact with people experiencing homelessness. HMIS assures that people who are experiencing chronic homelessness are prioritized for housing across the state and helps case managers' better support people who are homeless. The State has not consistently funded HMIS. This has put pressure on other funding sources such as Continuum of Care organizations and service providers.

Housing Benefits 101

HB101.org connects people to housing services, helps them understand their options, and provides tools to help them plan for housing. HB101 also holds information and resources for many other DHS Housing related programs such as Housing Support, General Assistance, and Minnesota Supplemental Aid. In 2021 alone, over 74,000 people used HB101.org over 113,500 times. This vital resource is currently funded through rebalancing funds from Money Follows the Person.

Heading Home Corps

The Heading Home Corps is a new Americorps program that launched in the summer of 2021 with fiscal support from the federal Corporation for National and Community Service. The Heading Home Corps engages a team of Housing Resource Navigators in helping Minnesotans work towards safe and stable housing. At present, there are approximately 40 sites statewide for Heading Home Corps members, including Compassion House in Detroit Lakes, Hope4Youth in Anoka, Neighborhood House in St. Paul, and Catholic Charities in St. Cloud, among many others. ServeMinnesota secured three years of Federal Funding to support the launch of the Heading Home Corps. The funding supports up to 100 AmeriCorps members each year and totals $7.3 million in Federal funds, including the AmeriCorps education scholarships of $630,000 available to AmeriCorps members to pay back student loans or further their education. Currently, there are no state matching funds for the Heading Home Corps program. As a result, participating housing organizations pay higher fees to sustain this critical work. In some cases, the fees may prohibit organizations from participating which may lead to inequitable statewide access.

HCBS Spending Plan and the Community Living Infrastructure grants

Section 9817 of the American Rescue Plan Act provided qualifying states with a temporary 10 percentage point increase of the federal medical assistance percentage (FMAP) on Medicaid expenditures for home and community based services (HCBS). In order to receive this enhanced match, states are required to reinvest the funds in approved expenditures that enhance, expand, or strengthen Medicaid home and community based services.

During the 2021 legislative session, the legislature appropriated funds for over 50 unique projects funded through the Home and Community Based Services (HCBS) FMAP dollars. Minnesota subsequently submitted the initial spending plan to CMS on July 13, 2021 detailing these investments authorized by the Legislature and the plan was approved by CMS on January 24, 2022.

One project within the HCBS spending plan is the Community Living Infrastructure grants of $11 million per year from 2022 through 2024. These grants provide funds to agencies for three purposes: 1) Outreach services to connect homeless individuals to various services, 2) Housing Resource Specialist services to assist individuals with obtaining required documentation so they can access housing; and 3) administration and monitoring of the Housing Support program. Expanded funding from the 2021 legislative session included direct assistance to individuals to access or maintain housing in community settings, including funds for lease or rent deposits, security deposits and utility set up costs. These grant expenditures were initially approved by the federal government on January 24, 2022, however certain expenditures may now be not eligible to be included in the plan.

Proposal:

This proposal includes the following provisions:

1. **Housing Stabilization Services (HSS) Benefit Expansion.** This proposal provides ongoing funding for HSS moving expenses to continue beyond March 2024, when the federal temporary funding ends. It also clarifies that eligible populations are those that are moving to their own homes from provider-controlled settings.
2. **Housing Stabilization Services (HSS) Payment Rate Update.** This proposal adds an inflationary increase to Housing Stabilization Services rate every two years, based on the consumer price index, allowing services to keep pace with inflation.
3. **Housing Stabilization Services (HSS) Administrative Support.** Since its implementation, demand for HSS has been significant, far exceeding the number of predicted participants. As a result, the program requires an additional policy staff person, seven additional eligibility staff, and a supervisor. The 2021 Legislature authorized temporary funding to hire these positions until March 2024. Ongoing salary costs are needed to maintain these critical positions so people can continue to access housing services in a timely manner. In FY 2024, a portion of a year is needed at $469,000 with total ongoing costs in FY 2025 of $1.237 million per year.
4. **Section 811 funding.** This proposal includes $300,000 per year for tenancy supports benefiting Section 811 participants to ensure ongoing sustainability of this important program.
5. **Homeless Management Information System (HMIS).** This proposal includes $250,000 in FY2024 and $1,000,000 per year starting in FY2025 and continuing as ongoing funding. HMIS funding to alleviate financial pressures on service providers and to enhance the system's capacity to target state and federal homelessness resources more strategically. Consistent investment in the base for the biennium will be instrumental in helping the state better understand the homeless population and connect individuals and families to needed resources.
6. **HB101 Funding.** This proposal includes an increase to the base of $280,000 per biennium and adds a 17L FTE to support the critical and expanding work of HB101 and HB101 Places. HB101 is currently funded by federal rebalancing funds from Money Follows the Person. This federal funding source requires states to seek permanent state funding. Maintaining HB101.org as a resource will ensure Minnesotan's can access needed information to attain needed services and most importantly, homes.
7. **Heading Home Corps.** This proposal includes $2.2 million as grant funding in fiscal years 2024/2025 to establish a state match for the AmeriCorps Heading Home Corps program, alleviating financial burdens on local service providers and ensuring more equitable access to housing resource navigators funded by this program.

8. **Home and Community Based Services (HCBS) Spending Plan Technical Correction.** This proposal provides a cost neutral technical correction clarifying the federal approval contingency for funds passed as part of the 2021 legislative session that were part of the HBCS spending plan. This technical change would clarify that the federal approval contingency is related to the initial spending plan approval by the Centers for Medicare and Medicaid (CMS), not an ongoing contingency throughout the time span of the HCBS spending plan. This change enables expenditures initially approved by the federal government to be included in the plan as meeting the intended contingency requirements in state law, while also ensuring that the state can meet contractual obligations to grantees if the federal government were to later disallow certain expenditures to be included as part of the federal spending plan.

Impact on Children and Families:

Housing Stabilization Services supports households where one-person age 18 or over is eligible for the services. The services have supported families when a parent is eligible for services, as well as youth aged 18 -24. HB101.org and HMIS support many families experiencing homelessness and housing instability.

Heading Home Corps members will primarily work with individuals experiencing homelessness, some of whom may be parents of children or another type of family member. Supporting these individuals and assisting them in accessing housing resources is an important investment in their stability, which may also positively contribute to their families.

In the 2018 Minnesota Homeless Study, 32% of those experiencing homelessness were children (17 or younger) living with their parents. This number has remained relatively flat since 2015. Many children experiencing homelessness attend school According to the Minnesota Department of Education, 9,000 students were identified as homeless at the beginning go the 2019-20 school year. For young children, homelessness means additional strain on academic and social well-being.

- 46% of parents experiencing homelessness reported that at least one of their children had to change schools because of their housing situation.
- 43% of parents reported at least one of their children had learning problems that required additional services.
- When asked about a set of experiences their school-aged child might have, the most common issues parents reported were experiences with bullying as a victim (42%) and difficulty with peer relationships (29%).

Homelessness and housing instability can contribute to poor health among all people, especially children and adolescents. Homelessness can contribute to the worsening of chronic conditions. Common health problems among homeless children and youth include:

- Greater incidence of illness and injury;
- Sexually transmitted infections (STIs) and unplanned or unwanted pregnancy;
- Mental health problems and substance use; and
- Increased risk of poor nutrition, heart disease and diabetes.

Equity and Inclusion:

Broadly, homelessness results from the intersectionality of multiple, systemic shortcomings that marginalize subsets of the population. Individuals are discriminated against based on their racial and ethnic identity, sexual orientation and/or gender identity, and/or ability status. The impact of this disparate treatment and access to opportunities manifests in many ways —one being the experience of homelessness. Although homelessness impacts individuals and families of all races, ethnicities, ages, genders, sexual orientations, and abilities, subsets of the population are disproportionately impacted. Racial disparities remain persistent across the state of Minnesota —most notably among the African American and American Indian populations. African Americans make up 39% of homeless adults, while being only 6.8% of the overall state population. American Indians make up 8% of homeless

adults, despite being only 1% of the statewide population. Statewide statistics also highlight the representation of individuals identifying as LGTBQ among those experiencing homeless. More specifically, 9% of homeless adults and nearly 18% of homeless youth (24 and under) self -identified as LGTBQ. Finally, as summarized by Wilder Research, “83% of homeless adults have either significant mental illness, chronic health condition, substance abuse disorder, or evidence of a traumatic brain injury. 44% have more than one of those conditions.”

Housing Stabilization Services dominantly serves BIPOC populations. Data from April 2022 showed that 44% of recipients on Housing Stabilization Services identified as Black, 5% identified as American Indian, 3% identified Latinx and 3% identified as multi-racial. This is unique for disability-based Medicaid services in Minnesota. Minnesota doesn’t consistently track LGBTQAI demographics, so are not able to identify people served from this population. However, we do know from reviewing applications and the accompanying housing plans that Housing Stabilization Services is serving this population. Housing Stabilization Services originated to increase equity in housing service access and appears to be meeting that purpose. To maintain equity, the services must be prioritized and funded appropriately.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

HB101.org and HMIS are administered by the State. The State works closely with tribal partners to support success. Tribes and tribal entities can and have enrolled in Housing Stabilization Services. Supporting administrative and policy Housing Stabilization Services staff at the state level, expanding the HSS benefit to include moving expenses, and adding inflationary rate adjustments will have a positive fiscal impact for enrolled Tribal providers. The Housing Stabilization Services Team has sought tribal feedback through the Minnesota Tribal Collaborative on all components of Housing Stabilization Services development. We intend to continue to work with Tribal partners to ensure ongoing relationships, outreach, and effective service development for Native American and Indigenous recipients.

Impacts to Counties:

Housing Stabilization Services, HB101.org and HMIS are all administered by the State. The State works closely with county partners to support success. There is no adverse fiscal impact on the counties related to this proposal. Counties can enroll in Housing Stabilization Services. Supporting administrative and policy Housing Stabilization Services staff at the state level, expanding the HSS benefit to include moving expenses, and adding inflationary rate adjustments will have a positive fiscal impact for enrolled counties.

IT Costs

There are no systems costs with this proposal.

Results:

The Housing & Support Services Division analyze Medicaid Management Information System (MMIS) and Housing Stabilization Services SQL table data to understand Housing Stabilization Services participant demographic and usage patterns. In the third year of implementation the team will be developing a consciously diverse cohort study to track usage and outcomes of the program over time. The data team also uses HMIS data to examine race of individuals receiving assistance, amount and source of the person’s income, and housing stability across multiple DHS-based income support and housing programs.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Number of people accessing Housing Stabilization Services		10,000	07/01/2022
Quality	BIPOC population Diversity of people accessing Housing Stabilization Services		55%	04/01/2022
Results	People moving to their own home using Housing Stabilization Services	TBD		

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			3,495	7,774	11,269	8,712	9,572	18,284
HCAF								
Federal TANF								
Other Fund								
Total All Funds			3,495	7,774	11,269	8,712	9,572	18,284
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	33 LTC	MA Housing Stabilization Services- extending transition benefits	63	393	456	413	433	846
GF	33 E&D	MA Housing – extending transition benefits- Ch/Eld/Dis MC	245	1,534	1,779	1,611	1,691	3,302
GF	33 MC	MA Housing- extending transition benefits- Adult MC	17	105	122	111	116	227
GF	15	MA Housing Stabilization FTEs	469	1,237	1,706	1,237	1,237	2,474
GF	15	HMIS	250	1,000	1,250	1,140	1,140	2,280
GF	15	Section 811	300	300	600	300	300	600
GF	15	HB 101	140	140	280	140	140	280
GF	15	HB 101 One FTE 17L	141	165	306	165	165	330
GF	56	AmeriCorps Heading Home Corps	1,100	1,100	2,200	1,100	1,100	2,200
GF	33 LTC	MA Housing Stabilization FFS – Inflationary Adjustment- MA LTC HCBS	229	523	752	667	813	1,480
GF	33	MA Housing Stabilization Fam w Ch/Edl & Dis MC – Inflationary Adjustment	895	2,045	2,940	2,603	3,173	5,776
GF	33	MA Housing Stabilization MA Adult MC- inflationary adjustment	62	141	203	179	218	397
GF	REV2	FFP @ 32% for BHDH admin	(416)	(909)	(1,325)	(954)	(954)	(1,908)
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	15	BHDH FTE's	10	10	20	10	10	20

Change Item Title: Strengthening Adult Income Supports

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	1,162	4,591	7,251	7,546
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	1,162	4,591	7,251	7,546
FTEs	**1**	**1**	**1**	**1**

Recommendation:

Effective January 1, 2025, the Governor recommends improving the effectiveness of Minnesota Adult Income Support programs by reforming outdated payment policies for certain Housing Support program participants. This proposal invests $5.753 million in the FY 2024-25 biennium and $14.797 million in the 2026-27 biennium.

This proposal includes the following provisions:

1) Eliminates inequities in individual benefit calculations between Minnesota Supplemental Aid (MSA) and Housing Support;
2) Changes the definition of countable income for people living in Housing Support community-based settings who receive unearned income such as SSI, RSDI, or Veteran's benefits to a 30% of income model;
3) Excludes Tribal per capita as counted income for Minnesota income support and child care assistance programs; and
4) Excludes lived experience income earned by people experiencing homelessness as counted income for Minnesota income support and child care assistance programs.

Rationale/Background:

The Housing Support program pays for room and board for older adults and adults with disabilities who have low incomes. The program aims to reduce and prevent people from living in institutions or becoming homeless.

Over 20,000 Minnesotans receive Housing Support assistance each month to help pay for rent and food. About 27% of program recipients also receive Housing Support supplemental service funding to provide other services, including but not limited to medication reminders, assistance with transportation, arranging for meetings and appointments, and arranging for medical and social services.

Housing costs (rent or mortgage and utilities) are generally considered affordable if they are 30% or less of a person's income. For this reason, most rental support programs cap the tenant share at 30% of income. Currently, Housing Support participants receiving Social Security Income (SSI), Retirement, Survivors, and Disability Insurance (RSDI), and federal veteran's benefits can be required to pay up to 90% of their monthly benefits. This leaves individuals with just over $100 each month to pay for basic needs such as: transportation, phone, personal hygiene items, clothing, home supplies, and child support. The burden of this obligation is enough to cause

eligible individuals to decline the program entirely and choose to remain in emergency shelter or places not meant for human habitation. For those in housing, it puts them at risk of eviction and limits their ability to build the savings needed to achieve greater financial and housing independence.

Proposal:

This proposal includes four program changes, each addressing a specific programmatic limitation or inequity, and administrative provisions to sustain resources and programming:

1. **Eliminate inequities in individual benefit calculations between Minnesota Supplemental Aid (MSA) and Housing Support.**

Housing Support program recipients who receive Supplemental Security Income (SSI) and have a representative payee help them manage their SSI benefits have their entire representative payee fee deducted from the income counted by the Housing Support program before their client obligation is determined, so they can pay that fee without reducing their personal needs allowance. In contrast, MSA allows for a special needs payment to help pay a recipients representative payee fee, but the MSA statute limits the amount to $25 – an amount that has not changed since 1996.

This proposal would tie the MSA special needs payment intended to cover the representative payee expense to the maximum amount calculated annually by the Social Security Administration (currently $48 per month in 2022). This change will close the gap between two groups of adult income support recipients and prevents the need to revisit the amount of the MSA representative payee special needs payment. This will have a fiscal impact of $719,790 in FY24-25 and $1,102,186 in FY26-27.

2. **Change the definition of Housing Support countable income to 30% of a recipient's unearned income, after allowable exclusions and disregards.**

Housing Support requires recipients with unearned income to contribute most of their unearned income toward their housing costs. At present, people with unearned income retain $121 of their income, as a personal needs allowance. DHS hears regularly from stakeholders (often from homeless outreach and supportive housing providers) that people with unearned income who *could* use Housing Support, choose not to use it, opting to retain control over their income. In many cases, the person is declining to participate in a Housing Support program in a community-based supportive housing setting with their own lease. Too often, this results in people staying in sheltered or unsheltered homelessness. Additionally, when people contribute most of their unearned income to their housing costs, they are unable to save enough money to meet other financial goals.

This provision modifies the definition of Housing Support countable income to 30% of a recipient's total countable income, after allowable exclusions and disregards, for recipients who live in a Housing Support community-based setting and who receive any unearned income. This change would reduce disincentives to applying for Housing Support when a person has unearned income, to allow people in community-based settings keep more of their income for basic needs, allowing them to save money and achieve their financial goals.

The overall cost of this portion of the proposal is $4.273 million in the FY 2024-2025 biennium and $12.969 million in the FY 2026-2027 biennium. The funding includes an increase to Housing Support forecasted grants and enrollment changes. In addition, systems costs are needed to make changes in the MAXIS system. The Housing Support forecasted portion of the cost is $3.67 million for the FY 2024-2025 biennium and $12.767 million for the FY 2026-2027 biennium.

3. **Exclude Tribal per capita as counted income for Minnesota's income support and child care assistance programs.**

The State counts Tribal per capita payments when determining eligibility for adult, family cash, and child care assistance programs. This proposal would exclude Tribal per capita payments from countable income, thus removing a barrier that prevents per capita payment recipients from accessing much needed public benefit

programs or services. The overall cost of this portion of the proposal is about $607,000in the FY2024-2025 biennium and $494,000 in the FY2026-2027 biennium. The forecasted portion of the cost of this portion of the proposal is about $271,000 in the FY 2024-2025 biennium and $382,000 in the FY 2026-2027 biennium. This total includes increases to General Assistance grants and Housing Support grants. In addition, systems costs are needed to make changes in the MEC2 and MAXIS systems. The systems costs included in the total above includes both federal and state share.

4. **Exclude consulting income earned by people experiencing homelessness as counted income for Minnesota income support and child care assistance programs.**

When a person with lived experience of homelessness receives compensation for consulting with health and human services entities, the income is counted. Counting this income reduces the incentive for people with lived experience to share their experience with human services delivery systems. For some people, counting this income puts their benefits at risk or makes them ineligible for benefits. This proposal excludes income received in exchange for the consultation of a person with lived experience. Removing this disincentive will benefit DHS programs by creating a pathway to hear the perspective of the people DHS serves.

Impact on Children and Families:

Most of the elements of this proposal are not expected to have a significant impact on children and families. Excluding tribal per capita payments for Minnesota income support programs and child care assistance programs, is anticipated to have a significant impact on American Indian families receiving available benefits.

Equity and Inclusion:

This proposal ties the allowable Minnesota Supplemental Aid (MSA) special needs payment amount to the federally allowable rep payee fee determined by the Social Security Administration. The end result is eliminating the inequity of fees between two of Minnesota's public assistance programs. Nearly half of the 30,821 (as of March 2022) recipients receiving MSA are Black, Indigenous and People of Color. Ensuring that MSA recipients are treated fairly compared to other public assistance program recipients is a critical step in building equity into the program.

The Housing Support Program is intended to serve low-income Minnesotans who are elderly or have a disability. Nearly 30% of the state's 21,000 Housing Support recipients are Black, Indigenous, and People of Color (BIPOC). The group with the greatest hesitation to use Housing Support to move into a supportive housing setting is from people who are currently experiencing sheltered or unsheltered homelessness. BIPOC people represent 61.2% of people experiencing homelessness, according to the Wilder 2018 study on homelessness. Changing the way that income is counted to allow more Housing Support recipients to keep a greater amount of their federal benefits, is a critical step in advancing equity for BIPOC individuals.

The 2018 Minnesota Reservation Homeless Study conducted by the Wilder Foundation found that Reservation respondents reported low utilization of public benefits and services. The report notes that people experiencing homelessness on Reservations may need greater support to connect to public services and benefits. Eliminating an additional barrier with the tribal per capita payment exclusion is one step the State can take to promoting greater equity for tribal citizens.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Elements of this proposal will have a significant impact on disparities for tribal program recipients. The Housing Division needs more feedback about potential impacts from tribes.

Results:

1. **Eliminate inequities in individual benefit calculations due to representative payee fees between Minnesota Supplemental Aid and Housing Support.**

This proposal will result in more available income for MSA recipients with representative payees and is not expected to significantly increase the overall number of MSA recipients.

2. **Increase the number of Housing Support recipients in community-based supportive housing settings who have unearned income.**

As noted above, people with unearned income often decline to participate in a Housing Support program in a community-based supportive housing setting with their own lease. Too often, this results in people staying in sheltered or unsheltered homelessness. Additionally, when people contribute most of their unearned income to their housing costs, they are unable to save enough money to meet other financial goals.

3. **Exclude Tribal per capita as counted income for Minnesota income support programs.**

This proposal will result in higher income support program participation rates for American Indians with Tribal per capita payments.

4. **Exclude consulting income earned by people experiencing homelessness as counted income for Minnesota's income support programs.**

This proposal will result in an increased income for people experiencing homelessness who participate in consulting work for DHS and other human services delivery systems.

Impacts to Counties:

This proposal is not likely to have a significant impact to counties. The primary impact to counties will be training eligibility workers on new policies.

IT Costs

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll						
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)	**1,342,888**	**268,578**	**268,578**	**268,578**	137,869	137,869
Total	**1,342,888**	**268,578**	**268,578**	**268,578**	**137,869**	**137,869**
MNIT FTEs	13					
Agency FTEs						

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			1,162	4,591	5,753	7,251	7,546	14,797
HCAF								
Federal TANF								
Other Fund								
Total All Funds			1,162	4,591	5,753	7,251	7.546	14,797
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	15	BHDH Admin (1 FTE)	141	165	306	165	165	330
GF	REV1	FFP @ 32%	(45)	(53)	(98)	(53)	(53)	(106)
GF	24	MN Supplemental Assistance Grants- Eliminate inequities	228	492	720	531	571	1,102
GF	23	General Assistance Grants- tribal cap	6	16	22	17	18	35
GF	25	Housing Support Grants	0	3,670	3,670	6,274	6,523	12,797
GF	11	MEC 2 Systems Cost- 55% state share	43	9	52	9	9	18
GF	11	MAXIS Systems Cost – 55% state share	695	137	832	137	137	274
GF	25	Housing Support Grants- tribal cap	47	78	125	88	92	180
GF	21	MN Family Investment Program- tribal cap	47	77	124	83	84	167
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
			1	1		1	1	

Statutory Change(s):

256I

Change Item Title: Reducing Recidivism through Evidence-Based Community Housing Interventions

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditure	817	1,827	1,943	1,976
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	817	1,827	1,943	1,976
FTEs	**2**	**2**	**2**	**2**

Recommendation:

The Governor recommends an investment of $2.644 million in FY 2024-2025 and $3.919 million in FY 2026-27 to prevent homelessness, increase housing stability, and reduce recidivism for people re-entering the community after release from a Minnesota correctional facility. This proposal establishes ongoing funding for the successful Bridging Benefits project and establishes Housing Support presumptive eligibility for people with disabilities leaving Minnesota prisons without stable housing for up to three months.

Rationale/Background:

Stable housing is critical to successful reentry into Minnesota communities. When individuals are released from incarceration, access to employment, housing, positive connections in the community, and medical care and medication are directly connected to greater public safety. In calendar year 2021, almost 25% of people were released from Minnesota correctional facilities were to sheltered or unsheltered homelessness. Over 50% of people released to sheltered or unsheltered homelessness are Black, Indigenous, and People of Color.

The Bridging Benefits project (formerly known as the “Joint Departmental Initiative”) provides people identified as having a “high” or “very high” risk of recidivism with integrated case management and helps them apply for health insurance and other public assistance (cash, emergency aid, food, or housing) prior to their release from incarceration. This program is a collaboration between Minnesota’s Departments of Corrections and Human Services aimed at reducing recidivism by improving people’s wellbeing and stability in the community.

The program began in 2017 as a pilot project and was initially funded through the Minnesota Statewide Initiative to Reduce Recidivism, an effort funded through a grant to the Department of Corrections from the U.S. Bureau of Justice. The program continues to be funded jointly by the Department of Corrections and Department of Human Services. As part of the program, DOC compiles lists of participants with upcoming release dates. DHS staff contacts and assesses the identified people for benefits in the month prior to their release. This involves DHS staff contacting and coordinating with correctional facility staff to identify periods when an incarcerated participant might be free for the required interview to assess eligibility for benefits and to identify service needs such as housing, disability, and behavioral health.

Upon release, DHS Initiative staff assist in coordinating benefits, and meet people where they are at when possible. When participants’ benefit cases are transferred to their county of service, DHS Initiative staff follow-up with financial workers, parole agents, and participants to ensure that required application materials are turned in and that the person has access to services that will support them living and thriving in the community.

Numerous studies demonstrate the benefits of stable housing for people exiting corrections. A 1999 study of recidivism in New York City found those living in temporary shelters upon release faced greater challenges in resisting drugs and finding jobs. People who were expecting to rely on shelters for housing upon release were also over seven times more likely to flee from parole supervision than people who said they were not going to be living in a shelter after release (Nelson, Deess, & Allen 1999). Supportive housing, and housing stability has been shown to reduce emergency department use, hospital admissions, and follow-through with psychological and substance use disorder treatment. (Culhane, Metraux, & Hadley, 2002; Makarios, Steiner, &Travis III, 2010). Such healthcare system utilization has also been shown to help predict recidivism (Gendreau, Little, & Goggin, 1996; Olver, Stockdale, & Wormith, 2011).

Recent program evaluations estimated that Bridging Benefits participants were less likely than people in a comparison group to have a new incarceration. The difference was largest within the first year of release, with the odds of having a new incarceration being nearly two-thirds lower for CAF Pilot Initiative participants than for people in the comparison group. Within three years of release, CAF Pilot Initiative participants were nearly half as likely as people in the comparison group to have a new incarceration. In addition, on the first year after release, the odds of becoming homeless were about one-third less for program participants than for people in the comparison group.

The 2021 Legislature temporarily increased staffing for the Bridging Benefits program. The temporary funding allowed DHS/DOC to improve ongoing case management and to support new counties. The funding is set to expire at the end of March 2024.

Proposal:

This proposal prevents homelessness, increases housing stability and reduces recidivism in two ways.

First, the Bridging Benefits project connects people identified as high-risk for recidivism to public benefits like food, health care, supportive services, and cash assistance programs. Additionally, it connects people to resources to help them apply for federal disability benefits. The Bridging Benefits project began as a pilot project in 2017 with one FTE. This program has been proven to reduce recidivism by 49% and homelessness by 26% after three years. Based on the success of this program, the state received temporary funding to expand the project statewide by hiring two additional FTEs to support the expansion. This proposal provides ongoing funding for the two FTEs at a MAPE 14L level.

Second, this proposal establishes a transitional basis of eligibility for the Housing Support program to allow a person who would otherwise have been released to sheltered or unsheltered homelessness to have the time and space to establish greater stability. This provides up to three months of Housing Support eligibility, to allow time for people to apply for on-going assistance. Similar transitional eligibility for Housing Support already exists for people leaving residential behavioral health treatment. The transitional basis of eligibility is available in all authorized Housing Support settings, which includes the possibility of permanent supportive housing.

Housing Support Presumptive Eligibility is estimated to cost $506,719 in FY2024, $1,619,473 in FY2025, $1,687,009 in FY2026, and 1,720,724 in FY2027. The fiscal impact of this proposal is based on 2021 data from the Department of Corrections (DOC), which shows there are 1,128 people released into sheltered or unsheltered homelessness, most of whom are expected to have a certified disability or disabling condition. On average 94 people per month would qualify for the presumptive eligibility and it is assumed there would be a 50% take up rate and 2.5 months of presumptive Housing Support use. This group is estimated to have average Housing Support payments equal to the Housing Support room and board base rate.

Impact on Children and Families:

The transitional basis of eligibility for Housing Support is available to any person with a disability leaving a Minnesota Correctional Facility without stable housing. In most cases, the primary beneficial impact will be to

single adults and childless couples; although the Department of Corrections is working on keeping incarcerated mothers with their children, so that is a growing population for the Bridging Benefits project. A person released from a correctional facility without stable housing could also use the Housing Support transitional basis if the Housing Support provider serves families.

Equity and Inclusion:
According to the Department of Corrections' 2021 Legislative Report, over half of individuals exiting into sheltered and unsheltered homelessness are Black, Indigenous and People of Color. By connecting these individuals to benefits and providing an opportunity for stable transition into housing, the state could alleviate some of these extreme inequities.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

This proposal is continuing the funding of FTEs related to connecting people identified as high-risk for recidivism to public benefits like food, health care, supportive services, and cash assistance programs. The proposal has no financial impact on tribes. By continuing funding of FTEs, the state relieves the burden put on people leaving correctional facilities and tribal staff of the coordination to start up food, health care, supportive services, and cash assistance programs. Tribes are aware of the existing program and the case maintenance required once individuals have been released.

Impacts to Counties:
This proposal is continuing the funding of FTEs related to connecting people identified as high-risk for recidivism to public benefits like food, health care, supportive services, and cash assistance programs. The proposal has no financial impact on counties. By continuing funding of FTEs, the state relieves the burden put on people leaving correctional facilities and county staff of the coordination to startup of food, health care, supportive services, and cash assistance programs. Counties are aware of the existing program and the case maintenance required once individuals have been released.

IT Costs
This proposal has systems impacts for a total cost of of $427 thousand in FY 2024, $85 thousnd in FY 2026, and $85 thousand in FY 2027. MN.IT estimates the need for 8.5 FTEs to complete this work.

Results:

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Number of people participating in the Bridging Benefits project per year			
Quality	Percentage of people who gain access to public benefits who are homeless upon leaving incarceration			
Results	People who participate in the project who have shown reduced recidivism and reduced homelessness			

The transitional basis of eligibility for people being released from a corrections facility is new for the Housing Support program. Performance will be measured in three ways:

1. Monitoring the number of people referred to the new basis of eligibility leading up to release from a corrections facility.
2. Monitoring the number of people who use the new basis of eligibility. This may include the number of providers that accept Housing Support referrals for people releasing from a corrections facility.
3. Measuring the reduction in the number of people who are released from a corrections facility into sheltered or unsheltered homelessness.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			817	1,827	2,644	1,943	1,976	3,919
HCAF								
Federal TANF								
Other Fund								
Total All Funds			817	1,827	2,644	1,943	1,976	3,919
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	15	BHDH admin	112	306	418	306	306	612
GF	REV1	FFP @ 32% for administrative costs	(36)	(98)	(134)	(98)	(98)	(196)
GF	25	Housing Support – Presumptive Eligibility	507	1,619	2,126	1,688	1,721	3,409
GF	11	MAXIS Systems Cost	234	0	234	47	47	94
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	15	Bridging benefits FTEs	2	2		2	2	

Statutory Change(s):

Section 256I.04

Change Item Title: Increasing Health Care Access for Minnesotans

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	9,049	3,363	3,371	3,371
Revenues	0	0	0	0
Other Funds				
Expenditures	0	1,077	10,082	12,000
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	9,049	4,440	13,453	15,371
FTEs	**9**	**12**	**12**	**12**

Recommendation:

The Governor recommends $13,489,000 in FY2024-2025 and $28,824,000 in FY2026-2027 to improve the enrollment and user experience for people applying for or enrolled in public health care programs by reducing language, accessibility, and technological barriers that hinder success. This proposal also expands MinnesotaCare eligibility to undocumented children in families with income at or below the 200% of the Federal Poverty Level (FPL).

Rationale/Background:

This proposal reflects opinions and ideas gathered from consumers, eligibility workers, navigators, and other Minnesota public health care program stakeholders about how to improve access to health care coverage. Improving the eligibility and enrollment process for consumers will significantly enhance the experience and the likelihood of successful enrollment for all eligible Minnesotans. This proposal would also expand access to health care coverage for undocumented Minnesota children under the age of 19 through MinnesotaCare.

Proposal:

This proposal seeks to improve the experience and likelihood of success for people applying for or enrolled in public health care programs by reducing language barriers. In addition to increasing access to health care, reducing these barriers may, in turn, lessen the administrative burden for front-line eligibility workers who are frequently called upon to assist applicants and enrollees with overcoming these obstacles. Many of the items in this proposal are in response to issues brought forward by stakeholders about facets of the eligibility and enrollment process that can make it more difficult for people, especially those with limited English proficiency (LEP), to successfully navigate Minnesota Health Care Programs (MHCP).

This proposal recommends the following investments to enhance and improve the enrollee experience for public programs:

Improve the applicant/enrollee experience

1. *Improve language accessibility of MHCP applications and consumer-facing forms.*
   This invests in improving MHCP applications and forms and translating additional materials used by consumers into multiple languages.

DHS requests three FTEs (Health Care Eligibility & Access (2) and the Health Care Eligibility Operations (1)), to carry out this work. These staff include:

- 1 analyst to create and maintain a library of eligibility and enrollment forms, monitor issuance dates, create and prompt a recurring schedule for regular reviews and periodic translations for all forms, carry out reading level testing and monitoring, archive obsolete forms and ensure forms standards are met and maintained.
- 2 analysts to review and continuously innovate and improve forms, carry out stakeholder engagement and test forms for consumer ease, usability and operational efficiency, produce annual updates to all application and renewal forms, monitor applications and forms used by other states for best practices and respond to requests for new forms, issue the associated bulletins, develop and deliver associated training for processing entities and assisters

This portion of the proposal also includes an investment of $350,000 for Interactive Voice Response (IVR) upgrades and $1,000,000 for translation services.

2. *Enhance the Minnesota Eligibility Technology System (METS) consumer and assister portals*

This will make critical improvements to the METS online consumer and assister portals and implement related changes to meet consumer, navigator and other assister needs, and eliminate paper-driven processes.

METS improvements will enable consumers (applicants and enrollees) and assisters to:

- Self-report changes in circumstances between annual renewals online and provide associated documented online; and
- Elect to receive electronic eligibility notices and permit notifying communications such as text messages and email alerts, rather than receiving eligibility notices by U.S. mail.

Additionally, this proposal will fund improvements to the worker account creation, enrollee online renewal and renewal document upload functionality, and ensure information provided by and about consumers' authorized representatives is included in expanded electronic communications through the METS to MMIS interface.

Proposed upgrades to METS reflect current consumer and assister needs and expectations for a real-time frictionless, and effective, online experience. In addition, these changes would fully implement federal Medicaid regulations that require states to provide enrollees with the option to receive notices electronically[2]. Reducing the number of notices mailed to MHCP enrollees could result in significant administrative savings; total costs for these mailings are estimated to be $1,031,712 for 2023.

This provision would require an up-front IT investment of $5,993,000 in state share; 20% is assumed per fiscal year thereafter for ongoing maintenance.

DHS requests four FTEs (Health Care Eligibility & Access (1) and the Health Care Eligibility Operations (3), to carry out this work. These staff would:

- 1 FTE (HCEA) will research, develop and maintain business rules consistent with ensuring data privacy and complying with Medicaid requirements for various consumer online transactions, and to participate on the IT project team.
- 1 FTE (HCEO) will support text messaging and document management.
- 1 FTE (HCEO) will develop, conduct and maintain worker and assister training.

- 1 FTE (HCEO) will participate on the IT project and provide ongoing support for new technology.

3. *Invest in Community Driven Healthcare Improvements*

DHS will engage in more meaningful community engagement by contracting with community-based organizations to facilitate conversations with MHCP enrollees. This enrollee-provided insight will allow MHCP to be more responsive to the needs of Minnesotans, and to ensure that programs are tailored to meet Minnesotans where they are. Funding would go towards meeting facilitation, processing information gathered with DHS leadership, stakeholder recruitment, and follow-up with individual participants. The cost includes funds to offer reasonable hospitality for meetings and stipends for participants that honor the value of their time and expenses incurred through participation. By offering this funding through contracts, DHS would leverage the expertise and experience of pre-trained and trusted community co-creators and navigators who can assist in supporting enrollees' participation in conversations, and also follow up with them regarding any unmet social needs that are identified in the course of engagement.

In addition to $1,020,000 each fiscal year in contract dollars, DHS requests three FTEs for this component of the proposal:

- 1 FTE to administer the contracts and facilitate recommendation development for the service delivery portion of the contracts;
- 1 FTE to administer the contracts and facilitate recommendation development for the eligibility and enrollment portion of the contracts, and;
- 1 FTE to address programming and policy to combat health disparities and inform policies that address social determinants of health and their impacts.

This provision of HC-65 does not have an IT impact.

Coverage Expansions

4. *MinnesotaCare Coverage for Children who are Undocumented*

This will make state funded MinnesotaCare available to uninsured children who are undocumented and in families with incomes at or below 200% FPL.

According to the State Health Access Data Assistance Center (SHADAC), about 17.6% of uninsured Minnesotans are undocumented noncitizens. This population is unlikely to have access to ongoing health care coverage today, as they are generally barred from most public programs, and currently only qualify for health care coverage (i.e., Medical Assistance) during pregnancy, or when they have a medical emergency. Immigrants, especially those who are undocumented, have been doubly disadvantaged by the COVID-19 pandemic, in that they are more likely to be furloughed or laid off and more likely to be frontline workers in critical industries at increased risk of contracting the virus.[1] Undocumented children are particularly vulnerable, as they may deal daily with isolation from peers, fears of discovery, detention and deportation, and for some, the trauma of being separated from their parents and family.

IT changes are needed in METS and MMIS systems to support this new MinnesotaCare coverage group.

DHS requests 2 FTEs (Health Care Eligibility Operations) to process applications and manage the additional MinnesotaCare cases that will result from this change. This provision will also require a contract amendment of $130,000 in total dollars to account for eligibility impacts on the Child and Teen Check-up and vaccine outreach programs and prior authorization needs once fully implemented.

[1] Minnesota Compass, Minnesota's workers of color and immigrants bear the brunt of COVID-19's impact, September 15, 2020. Retrieved July 1, 2022.

Impact on Children and Families

Minnesotans currently eligible for MHCP face significant barriers to enrollment, partially due to the complexity and rigidness of current eligibility systems used by DHS and processing entities. The improved user experience envisioned in this proposal will increase access to Minnesota Health Care Programs by:

- Reducing application errors and worker involvement by improving forms usability and language translation;
- Inviting stakeholder participation in more formalized ways to improve programs and better serve Minnesotans;
- Additionally, expanding MinnesotaCare to undocumented children under 19 would allow vulnerable children to receive necessary health care services. In 2002, approximately 4 in 10 (42%) of undocumented noncitizens were uninsured, and due to immigration requirements of Medical Assistance, uninsured undocumented noncitizens are ineligible for any health care coverage, including through the private marketplace, unless they qualify on the basis of pregnancy or having a medical emergency.[2]

Equity and Inclusion:

These improvements to the applicant/enrollee experience and technological advancements for people to apply and enroll in MHCP would particularly benefit people of color and indigenous Minnesotans.

Undocumented noncitizens are at a high risk of being uninsured because they have limited access to coverage options.[3] Many delay or go without needed care, and while some can obtain low-cost care through community clinics, this care is often limited to preventative or primary care, leaving them with barriers to accessing specialty care or care for chronic conditions.[4] A lack of coverage is a significant problem for children, as cost concerns can lead to avoidance of needed care, and regular well-child visits are essential to track developmental milestones, receive immunizations, and identify/treat acute or chronic conditions.[5] Without coverage, children's health needs are less likely to be met, and this is especially concerning considering issues around health equity.[6] Expanding MinnesotaCare to undocumented children will reduce disparity in coverage rates between children who are citizens and those are who undocumented, which is the first step to improving health and educational outcomes for all children.[7]

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Throughout implementation of the "improve the applicant/enrollee experience" portion of this proposal, the DHS will engage with enrollees, processing entities (i.e., counties, tribes), and application assisters (i.e., navigators, certified application counselors) to ensure processes being built address the needs of all Minnesotans.

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[2] Kaiser Family Foundation, Health Coverage of Immigrants, April 6, 2022. Retrieved July 1, 2022.

[3] Kaiser Family Foundation, Health Coverage and Care of Undocumented Immigrants, July 15, 2019. Retrieved July 1, 2022.

[4] *Id.*

[5] Alker, J., & Osorio, A. (2021, October 8). Why is Medicaid/CHIP Continuous Eligibility So Important for Kids? Center for Children and Families, Georgetown University. Retrieved June 27, 2022.

[6] *Id.*

[7] *Id.*

Impacts to Counties:

Throughout implementation of the "improve the applicant/enrollee experience" portion of this proposal, the DHS will engage with enrollees, processing entities (i.e., counties, tribes), and application assisters (i.e., navigators, certified application counselors) to ensure processes being built address the needs of all Minnesotans.

IT Costs

This proposal includes $15.8m in funding for the state share of systems costs, as outlined above.

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Compare call logs before and after upgrades to quantify number of calls to clarify application. Compare phone logs for wait times Quantify changes in circumstances, timeliness submission of verification documents, and sign and return renewal paperwork.					
Quality						
Results	Examine enrollment trends after improved enrollment application process implements					

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			9,049	3,363	12,412	3,371	3,371	6,742
HCAF			0	1,077	1,077	10,082	12,000	22,082
Federal TANF								0
Other Fund								0
Total All Funds			9,049	4,440	13,489	13,453	15,371	28,824
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
HCAF	51	MinnesotaCare Grants	0	1,077	1,077	10,082	12,000	22,082
GF	13	HCA Admin - Contract	1,860	1,085	2,945	1,150	1,150	2,300
GF	13	HCA Admin - FTEs 9, 12, 12, 12)	1,213	1,879	3,092	1,826	1,826	3,652
GF	REV1	FFP @ 32%	(983)	(949)	(1,932)	(953)	(953)	(1,905)
GF	11	State Share of Systems	6,959	1,348	8,307	1,348	1,348	2,696
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	13	HCA Admin - FTEs (9, 12, 12, 12)	9	12		12	12	

Statutory Change(s):

Minnesota Statutes §256B.057
Minnesota Statutes §256L.04

Change Item Title: Increasing Access to Health Insurance for Minnesotans

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures- DHS	9,255	8,167	3,417	7,960
Expenditures- MNsure		4,200		3,460
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	9,255	12,367	3,417	11,420
FTEs	**0**	**0**	**0**	**30.5**

Recommendation:

The Governor recommends allowing additional Minnesotans to buy comprehensive health insurance coverage via the MinnesotaCare program. This proposal requires an investment of $21,622,000 in FY2024-2025 and $14,837,000 in FY2026-2027.

Rationale/Background:

Since the passage of the Affordable Care Act (ACA), Minnesota has been a leader in health insurance coverage and health innovation. However, many Minnesotans still do not have access to affordable health care, regardless of how and if they have health care coverage.

Minnesota's uninsurance rate of 5.3 percent in 2020 remains below the national average of 8.6 percent; however, the state no longer ranks in the top 10 states with the lowest uninsurance rates.[1] An estimated 294,000 Minnesotans remain uninsured, and, of those 294,000, about half are likely eligible for Minnesota Health Care Programs (MHCP), Medical Assistance or MinnesotaCare, as they exist today. Another 36.5 percent are likely eligible for advanced premium tax credits (APTCs) through MNsure. Additionally, even for insured Minnesotans, high out-of-pocket costs may prevent them from seeking necessary medical care. Minnesota has the highest rate of out-of-pocket (OOP) spending in the country ($3,750 annually), which is roughly twice the national average ($1,768 annually).

Research indicates that three groups of Minnesotans continue to need help accessing and affording health insurance:

- People who are uninsured;
- People in qualified health plans (QHPs) with unaffordable coverage (i.e., those with high deductible health plans); and
- People in employer-sponsored insurance (ESI) with unaffordable out-of-pocket costs.

Proposal:

This proposal expands coverage options by making MinnesotaCare available to people with incomes over 200% FPL, including undocumented noncitizens, as well as those with access to employer-sponsored coverage or other coverage that is deemed "affordable" according to federal guidelines. People who enroll via the buy-in must still meet all other MinnesotaCare eligibility requirements. Enrollment will be limited to MNsure's annual open enrollment period or special enrollment periods. DHS will develop a premium scale for enrollees with incomes over 200% FPL.

This provision would be effective January 1, 2027, or upon federal approval, and would require 30.5 FTEs upon full implementation. Duties of these FTEs would include processing enrollments, providing business expertise in systems testing, responding to health care eligibility appeals, corresponding with the federal government, and providing data analytics related to external stakeholder requests.

This provision would also require $400,000 in contract costs in FY25 and $100,000 in contract costs in FY26 to complete analysis related to a 1332 state innovation waiver, analysis related to tax implications and increasing provider enrollment in MinnesotaCare, and designing an alternative delivery system.

Lastly, this provision would require systems changes as outlined in the IT Related Proposals section below.

Impact on Children and Families:

Under this proposal, children and families will have better access to health insurance coverage. A recent report by SHADAC found that, nationally, 5% of children age 17 and under lacked health insurance between 2016-2020.[1] While the analysis showed that Minnesota's uninsurance rate for children was significantly below the national average at 3.3%, there is still room to improve access to health insurance for children and their families in Minnesota.

Equity and Inclusion:

According to a SHADAC analysis of 2018-2019 American Community Survey data, populations of color are overrepresented in the number of uninsured Minnesotans. Black Minnesotans represent 6.5% of the total population, but 11.3% of the uninsured. Similarly, Hispanic/Latino Minnesotans represent 5.5% of the total population, but 18.9% of the uninsured.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:

This proposal does not directly impact counties.

[1] State Health Access Data Assistance Center (SHADAC). 2022. *Room to Grow: Inequities in Children's Health Insurance Coverage*. https://www.shadac.org/sites/default/files/publications/Room%20to%20grow_KHIC_Brief_22.pdf.

IT Costs

Provisions in this portion of the proposal are estimated to impact the following systems:

- METS at an upfront cost of $9,309,299;
- MMIS at an upfront cost of $6,224,309, and;
- FileNet at an upfront cost of $1,047,521.
- Because of the magnitude of costs, this project will also require an Independent Risk Assessment at a cost of $440,000.

The METS, MMIS, and FileNet projects are all expected to take 24 months; upfront costs are split evenly across the first two fiscal years. For these three projects, ongoing costs are estimated at 20% of the upfront cost per fiscal year. No federal match is reflected for this work as it is assumed to be ineligible for federal systems funding.

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of uninsured Minnesotans					
Quality	Number of Minnesotans who enroll in the buy-in option	N/A	Sept. 2022	0	TBD	
Results	Minnesota uninsurance rate	4.0%	2021 MN Health Access Survey	TBD	TBD	Annual

Evidence-based Practice	**Source of Evidence**
Health insurance access	Expanding access to public health insurance. (Source: Finkelstein (2012), https://academic.oup.com/qje/article-abstract/127/3/1057/1923446)

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			9,255	12,367	21,622	3,417	11,420	14,837
HCAF								
Federal TANF								
Other Fund								
Total All Funds			9,255	12,367	21,622	3,417	11,420	14,837
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	13	HCA Admin (Contract)		400	400	100		100
GF	13	HCA Admin - FTEs (0,0,0,30.5)	0	0	0	0	4,643	4,643
GF	11	Systems modifications (METS)	4,655	4,655	9,310	1,862	1,862	3,724
GF	11	Systems modifications (MMIS)	3,112	3,112	6,224	1,245	1,245	2,490
GF	11	Systems modifications (Other)	1,488	0	1,488	210	210	420
GF		MNsure estimated costs		4,200	4,200		3,460	3,460
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	13	HCA Admin	0	0		0	30.5	

Statutory Change(s):

Minnesota Statutes, section 256L.04, subdivisions 1c, 7a, 10; adds a new subd. 15
Minnesota Statutes, section 256L.07, subdivisions 1, 2
Minnesota Statutes, section 256L.15, subdivision 2

Change Item Title: Supporting Tribal Providers and Payments

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	640	701	701	701
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	640	701	701	701
FTEs	**7**	**7**	**7**	**7**

Recommendation:

The Governor recommends changes to align Minnesota's Medical Assistance (MA) policies regarding tribal provider enrollment and payment with CMS requirements and investing resources for the Department of Human Services (DHS) to work with Minnesota tribes to explore new options for funding tribal health care systems as well as providing dedicated support to ensure the state Medicaid program can adequately support tribes and tribal health care systems. This proposal requires a General Fund investment of $1,341,000 in the FY2024-2025 biennium and $1,402,000 in the FY2026-2027 biennium.

Rationale/Background:

In 2016, the Centers for Medicare & Medicaid Services (CMS) issued guidance to states that established requirements for tribal providers for services that are provided outside of the four walls of the tribe's main tribal clinic or facility. This guidance is known as the "Four Walls" policy. Tribal providers that comply with the requirements may be eligible to receive the federally established daily all-inclusive rate (AIR) at 100% federal financial participation (FFP) for qualifying services rendered to tribal members. CMS recently delayed enforcement of this policy until nine months after the end of the federal COVID-19 Public Health Emergency (PHE).

The current method for payment to tribal provider systems is designed based on a Western medical model and does not adequately recognize and support tribal delivery systems and traditional native healing approaches. The CMS "Four Walls" guidance has reduced the flexibility for tribes to establish health care systems that include HCBS services and culturally appropriate services for tribal members that may not reside on tribal reservation land. Moreover, the "Four Walls" policy raises important concerns from tribes regarding related to tribal sovereignty and the trust responsibility from the U.S. Government.

Finally, as health care continues to rapidly evolve, tribes are expanding the services they provide to their communities with many services potentially covered by Medicaid. State Medicaid programs must collaborate with tribes in order to develop and implement policies and process that advance improvement of health outcomes in a manner that complies with federal Medicaid rules, and in certain circumstances states must also engage in formal consultation with tribes.

Proposal:

This proposal allows enrolled Indian Health Service (IHS) facilities or select tribal health centers to elect to enroll as a tribal Federal Qualified Health Center (FQHC) and directs the Department of Human Services (DHS) to establish an alternative payment methodology for tribal FQHCs. This change will align Minnesota's MA policies regarding tribal provider enrollment and payment with federal requirements that govern Medicaid payments to tribal providers.

This proposal is critical for the state to come into compliance with CMS requirements that will begin enforcement nine months after the end of the federal COVID-19 public health emergency, while also recognizing the real impact of changes to payment methodology that could negatively impact the ability of tribes to provide culturally appropriate services to members of their communities. DHS continues to work with tribes to reach compliance, reduce the risk of overpayments, and mitigate financial losses to tribal providers.

This proposal will also provide resources for DHS to work collaboratively with interested Minnesota tribal nations to identify one or more options that could modify the way Minnesota provides the federally required MA financing to tribes to support our shared goal of providing high quality, effective healthcare to their communities in Minnesota. Using this funding, DHS would continue working with the tribes to work towards development of an alternate health care financing mechanism that addresses the unique needs of tribal members and their ability to provide culturally appropriate services for their members. Participation in the development would be voluntary, as tribes can elect to keep the current system if they wish.

Finally, this proposal ensures DHS has sufficient, dedicated staffing to adequately support tribes as they develop and implement Medicaid services, helping provide needed technical assistance, policy and rate analysis, compliance review, and support for identifying and initiating tribal consultation when necessary.

Implementation of this proposal will be supported by seven FTEs:

- One FTE (MAPE 14L) in Provider Enrollment to be a lead on tribal enrollment and billing. Because this position systems-funded, DHS can claim state share at 29%.
- Two FTEs (both MAPE 17Ls), one in Purchasing and Service Delivery and one in Federal Relations, to offer tribal support and help to develop the alternative financing structure. Federal Financial Participation (FFP) is assumed at 32%.
- One 17M manager, one MAPE 17L, one MAPE 14L, and one AFCSME 64 administrative staff person to provide ongoing, dedicated technical assistance, review, and coordination of policies, rates, and federal compliance associated with tribal health systems and services covered by the Medicaid program. FFP is assumed at 32%.

Impact on Children and Families:

This proposal does not specifically impact children and families. However, it will help ensure that children and families who are tribal members have access to culturally appropriate services through Medical Assistance.

Equity and Inclusion:

This proposal will help ensure enrollees who are tribal members have access to culturally appropriate services. In addition, this proposal helps ensure that tribal providers continue to have resources necessary to provide access to services within their communities, helping reduce health disparities experienced by American Indians within the state. Reducing administrative burden and improving flexibility of how, where, and what services are provided can improve access to care and allow tribes to make additional investments into the care and services they provide.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

The CMS "Four walls" policy raises legitimate concerns from tribes regarding related to tribal sovereignty and the trust responsibility from the U.S. Government, and this policy change has been a priority issue for all of Minnesota's tribal nations since its announcement. DHS staff have been working with Minnesota's tribal nations to reach compliance, reduce the risk of overpayments, and mitigate financial losses to tribal providers. Work is underway with tribes to review current enrollment and payment information. DHS has conducted individual meetings with tribes to ensure their unique needs and objectives are understood and supported throughout this process.

Impacts to Counties:
This proposal does not impact counties.

IT Costs
This proposal requires changes to MMIS that will require an estimated 1,510 hours of work and 6 months for an up-front cost of $149,490. It is assumed there will be 20% in ongoing costs with state share at 29%.

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of enrolled tribal FQHCs	N/A				
Quality						
Results	Tribal provider claims for services outside of the clinic or facility are paid in accordance with federal guidance.					

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			640	701	1,341	701	701	1,402
HCAF								
Federal TANF								
Other Fund								
Total All Funds			640	701	1,341	701	701	1,402
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	HCA Admin - FTEs (1,1,1,1)	39	44	83	44	44	88
GF	13	HCA Admin - FTEs (6,6,6,6)	821	953	1,774	953	953	1,906
GF	REV1	FFP@32%	(263)	(305)	(568)	(305)	(305)	(610)
GF	11	State Share of Systems Costs (MMIS)	43	9	52	9	9	18
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	HCA Admin - FTEs (1,1,1,1)	1	1		1	1	
GF	13	HCA Admin - FTEs (6,6,6,6)	6	6		6	6	

Statutory Change(s):

Minnesota Statutes, section 256B.0625, subd. 30

Change Item Title: Improving the Minnesota Eligibility Technology System (METS) Functionality

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	17,550	483	483	483
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	17,550	483	483	483
FTEs	**4**	**4**	**4**	**4**

Recommendation:

The Governor recommends changes to the Minnesota Eligibility Technology System (METS) to conduct short-term emergency fixes, provide ongoing sustainability, and develop future recommendations. This proposal will require an investment of $18,033,000 in FY 2024-25 and $967 thousand in FY 2026-27.

Rationale/Background:

The COVID-19 public health emergency necessitated a re-prioritization of DHS and MNIT resources that included setting aside and redirecting funding earmarked for several in process and upcoming METS IT projects. These include projects to better support eligibility and case management for pregnant women and newborn infants, streamlining and updating the way METS gathers and calculates income for eligibility, and discovery toward improving the use of trusted electronic data sources to verify applicant and enrollee income. These METS projects will simplify the eligibility and enrollment process for applicants and help ease the administrative burden for county, tribal and DHS eligibility workers who manage health care cases in METS. Stakeholders support resuming these efforts to improve the enrollee experience, decrease unnecessary paperwork, and increase program integrity.

In addition to resuming pre-COVID emergency efforts, METS improvements are needed to advance operational efficiency, and close gaps that impede smooth programmatic transitions for enrollees and require manual workaround procedures for county, tribal and DHS workers.

Proposal:

This proposal will sustain current METS software and hardware functionality, fund priorities for core functionality issues that result in incorrect determinations and administrative burden for the state, counties, and tribes, and explore opportunities to further modernize and improve public health care eligibility systems through exploring technology solutions that other states in the country are using and making recommendations on future eligibility systems funding.

Because these METS changes will take place within the state's Advance Planning Document (APD) process, the state will be able to leverage significant federal funding, estimated to total $66.749 million for a state investment of $16.459 million.

Immediate fixes for METS
This provision will help fill funding holes for 24 priorities for METS core functionality issues that were first compiled in 2018, and to fund projects that were put on hold during the PHE. Most of these changes are needed in order to comply with federal law, and to eliminate manual workarounds that contribute to required eligibility worker hours at the state, counties, and tribes during a time when capacity is at a historic low.

Some of the specific fixes that this proposal includes are in the following list. More fixes and systems changes will be identified in the early stages of the project to ensure prioritization of the strongest pain points:

- **Maintaining eligibility on a case until a determination is made**: Renewals take place throughout the year for MA, and all at once at the end of the year for MinnesotaCare. The number of renewals can be overwhelming for both county and tribal agencies when processing for MA and for DHS when processing MinnesotaCare renewals. The sheer volume can cause processing delays, even when an enrollee returns their renewal promptly. METS must be programmed to permit a worker to record receipt of a renewal and to pause automatic case closure, until the renewal can be processed. This will prevent enrollees from losing coverage and allow processing agencies to catch up if they fall behind in renewal processing. When a case closes in METS, it cannot be re-opened and workers must manually transfer all the information from the closed case and enter it into the new case. This is time-consuming and only furthers processing delays. Additionally, this is confusing for enrollees, as they receive a case closure notice for not completing renewal, although they returned their renewal form timely. This confusion could be prevented by having functionality in METS to delay case closure when a renewal is received, but a determination has not yet been made.
- **Reinstatement for late processing**: If an enrollee returns their renewal timely, but the agency is not able to process it before the renewal deadline, METS will close the case. As mentioned above, a closed case cannot be re-opened, so county and tribal workers must reenter the case data and open an entirely new case, which is time-consuming for workers and confusing for enrollees. METS must be programmed to allow a closed case to be re-opened administratively.
- **Late renewals as new applications**: Minnesota statutes require that if an enrollee submits a late renewal, but it is within four months after closure for failure to renew, that the late renewal be processed as a new application. METS does not support this federally-required reconsideration period, so workers must reenter and open a new case for each late renewal. This creates many issues for both processing agencies and for enrollees. METS must be programmed to support processing late renewals as new applications during the four month reconsideration period.

Ongoing sustainability for METS
This provision will include investments identified by MNIT to support ongoing functionality of METS as future changes are being contemplated.

Future recommendations for METS
This provision will invest in four FTEs (MAPE 20L) and a vendor contract to respond to recommendations from the 2021 DHS Gartner Go Forward Strategy Report. The report identified that, while some portions of the METS platform may continue to be worth additional investment for Minnesota's Health Care Programs, it is also critical that the state consider other technology solutions to support eligibility determinations. The current METS system is expensive to maintain and make changes to, and a future system or systems may better support eligibility determinations while allowing more flexibility and responses to emerging federal and state requests and requirements.

FTEs will be permanent to give DHS the ability to continue to stay up to date on emerging technology in the public program eligibility determination space.

Impact on Children and Families:

These METS improvements would be a great benefit to both Medical Assistance and MinnesotaCare enrollees who are children and families. Workarounds in METS are often created to ensure compliance with federal law, as well as to make correct eligibility determinations. The end result of workarounds often includes families receiving multiple notices, new case numbers, and household members may be split onto different cases to achieve the correct eligibility determination. Improving METS functionality would not only prevent these confusing workarounds, but would improve the effectiveness of electronic verifications and integrity of income calculations, and would decrease the paperwork that applicants and enrollees must submit.

Equity and Inclusion:

This proposal will affect all applicants and enrollees equally, but should be of great assistance to people who speak English as a second language and those do not have access to a phone or computer by reducing the amount of paperwork send, as well as the need to call to ask questions.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

County and tribal nations would greatly benefit from METS improvements. Workarounds can be time-consuming and are often consuming to enrollees, which in turn increases the number of phone calls and questions county and tribal stakeholders must answer.

Impacts to Counties:

County and tribal nations would greatly benefit from METS improvements. Workarounds can be time-consuming and are often consuming to enrollees, which in turn increases the number of phone calls and questions county and tribal stakeholders must answer.

IT Costs

A state investment of $16.5 million will leverage federal funding for a total investment of over $83 million.

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Decreased renewal closures					
Quantity	Decreased number of cases closed and re-entered by workers due to workarounds and METS defects					
Quality	Increased program integrity					

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			17,550	483	18,033	483	483	966
HCAF					0			0
Federal TANF					0			0
Other Fund					0			0
Total All Funds			17,550	483	18,033	483	483	966
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	13	HCA Admin - FTEs (4,4,4,4)	604	711	1,315	711	711	1,422
GF	13	HCA Admin - Contract	1,000		1,000			
GF	REV1	FFP @ 32%	(513)	(228)	(741)	(228)	(228)	(456)
GF	11	State Share of Systems Costs	16,459		16,459			
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	13	HCA Admin - FTEs (4,4,4,4)	4	4		4	4	

Change Item Title: Responding to COVID-19 in Minnesota Health Care Programs

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	57,490	1,064	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	10,265	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	67,755	1,064	0	0
FTEs	**125**	**20**	**0**	**0**

Recommendation:

The Governor recommends an investment of $68.8 million in the FY 2024-2025 biennium for policy changes and resources to support the Department of Human Services' efforts to transition to normal eligibility policies and operations for Medical Assistance (MA) and MinnesotaCare (Minnesota's public health care programs, or MHCP) when the COVID-19 continuous coverage requirements end. This funding represents a reinvestment in MA and MinnesotaCare of enhanced federal funding that the state has received during the federal COVID-19 public health emergency (PHE); by mid-January of 2023, the state had received an estimated net of $1.780 billion in enhanced funding due to continuous eligibility requirements in those programs, which has gone to the General Fund. This proposal would use a small portion of that amount toward responding to federal unwinding requirements.

Rationale/Background:

The Families First Coronavirus Response Act (FFCRA) provided states with additional federal Medicaid funds for maintaining coverage for current and new Medical Assistance (Minnesota's Medicaid program) enrollees throughout the PHE. This 6.2 percentage-point increase in the Federal Medical Assistance Percentage (FMAP) for calendar quarters in which the PHE is in effect reduced the state share of Medicaid spending, which resulted in a savings to the General Fund. Currently, the enhanced federal financial participation had provided the state with an additional $1.780 billion of federal funding by mid-January 2023.

To receive the increased FMAP rate, states were required to meet the following Medicaid requirements:

- Ensure eligibility standards, methodologies, or procedures are not more restrictive than those in effect on January 1, 2020;
- Ensure premiums do not exceed the amounts as of January 1, 2020;
- Do not terminate enrollment unless an individual requests a voluntary termination of eligibility, dies, or ceases to be a state resident;
- Provide coverage (without cost-sharing) for any testing services and treatments for COVID-19, including vaccines, specialized equipment, and therapies, and;
- Do not increase the percentage of the nonfederal share required from local governments above that in place as of March 11, 2020.

While the treatment of MinnesotaCare enrollees was not addressed in FFCRA, DHS, in consultation with the Centers for Medicare & Medicaid Services, has applied the same or similar policies to MinnesotaCare enrollees to support continued coverage of individuals and families during the COVID-19 pandemic and to ensure continuity of coverage for similarly situated individuals.

Prior to 2023, the return to standard policies and procedures was tied to the end of the federal public health emergency (PHE) for COVID-19. However, the Consolidated Appropriations Act, 2022, signed by President Biden on December 29, 2022, decoupled the continuous coverage requirements from the PHE. States are now allowed to begin the unwinding of continuous coverage as of April 1, 2023. Additionally, the Consolidated Appropriations Act contained provisions to continue but wind down the 6.2% enhanced federal funding through calendar year 2023 as states begin to conduct eligibility renewals and restore standard policies and operations for their Medicaid caseloads.

Continuous coverage for current enrollees and not conducting renewals has created less churn in Minnesota health care programs and contributed to a lower volume of new applications. Applications for public health care programs have consistently remained at half of the rate they were pre-pandemic. Application volumes in 2021 were also slightly lower than they were at the same time during the pandemic in 2020. As the state continues to maintain coverage for current enrollees, DHS has witnessed less of this costly churn off and back on public health care programs. Without reapplications for lost coverage, the state has seen much lower application volumes than historically occur.

Proposal:

The unwinding of continuous coverage and resumption of eligibility renewals will be unprecedented, complex, and difficult. Several measures must be taken to ensure that eligible enrollees do not lose coverage. In addition, some vulnerable populations may need additional time to make necessary changes to retain their coverage after continuous coverage ends (for example, long-term care facility residents). Many Minnesotans will lose eligibility for public health care programs as Minnesota transitions back to standard MA and MinnesotaCare policies and operations.

This proposal seeks to ensure that DHS, in partnership with stakeholders, has resources to ensure as smooth of a transition as possible, while lessening adverse impacts to those who should remain eligible for MA and MinnesotaCare. To mitigate these potential impacts, and, importantly, to ensure that all Minnesotans retain access to the health care coverage for which they're eligible, DHS has several goals and objectives related to returning to nonemergency operations, which this proposal supports, including:

- Resuming standard eligibility functions in as timely of a manner as possible;
- Ensuring that the Minnesotans DHS serves have timely information about what is required of them and by when, and;
- Avoiding disruptions to services resulting from COVID-19 driven changes in circumstances.

To ensure a smooth transition for health care program enrollees during the unwinding process, DHS recommends the following actions:

Temporary Asset Disregard

While MA coverage has been maintained for enrollees during the PHE with limited exceptions since March 2020, some MA enrollees who are subject to an asset limit have accumulated assets above the program limits that they would not have ordinarily accrued.

This proposal would allow MA enrollees who are age 65 or older, blind or who have a disability, are subject to an asset test and who are identified as having excess assets at their first renewal following the end of continuous coverage, time to spend down accumulated assets to be within the program limit by the enrollee's second annual renewal. Providing the enrollee extra time after their first renewal to reduce assets should result in fewer enrollees losing coverage due to excess assets and will provide enrollment stability and mitigate unnecessary program churn for these vulnerable MA populations.

Suspension of MinnesotaCare Premiums during the Unwinding of Continuous Coverage
Generally, MinnesotaCare enrollees are subject to a monthly premium. Payment of the premium is required to initiate and maintain coverage. During the PHE, MinnesotaCare enrollees maintained coverage regardless of whether or not they paid their premium. Additionally, the 2021 legislature required that DHS not collect any unpaid premiums for coverage months that occurred during the public health emergency. This proposal would establish $0 premiums for MinnesotaCare through June 30, 2024, to support the transition of MA enrollees who become newly eligible for MinnesotaCare, and prevent gaps in coverage that occur due to premium requirements. MinnesotaCare enrollees will not be subject to a premium until the redetermination process is complete.

Support for Navigator Organizations
Navigator organizations play an integral role in helping Minnesotans access health care. Navigators not only help Minnesotans with applying for and enrolling in coverage, but also assist enrollees with annual renewals, reporting changes, and following up on any post-enrollment questions around accessing care. Additionally, many navigator organizations often have staff who can speak different languages and are active in the community and who work to increase awareness of health care options for the uninsured.

Navigators are paid per enrollment, via grant funds, to ensure that free assistance is available to all Minnesotans. While continuous enrollment during the PHE has been beneficial to enrollees, navigator organizations have been hit particularly hard because of their payment structure; more people maintaining coverage has resulted in decreased applications, which has impacted navigator organization funding. Furthermore, when continuous coverage ends, navigator organizations will play an essential role in assisting enrollees with the renewal process, particularly enrollees with limited English proficiency and in BIPOC communities.

As part of the 2021 Health and Human Services budget bill, the legislature repurposed unspent incentive program funds authorized by section 256.962, to appropriate one-time grant funding to support navigator organizations when there were fewer applications because of continued coverage provisions. This proposal would provide additional grant funding to navigator organizations to help support the agency’s work, acknowledging that eligibility redeterminations for the entirety of the MA and MinnesotaCare-enrolled population will require significant work on behalf of those organizations.

This proposal includes an additional $4.936 million in funding for navigator organizations in Fiscal Year 2024.

Resume Periodic Data Matching after the Unwinding of Continuous Coverage
Periodic data matching is an IT system process that uses trusted electronic data sources to identify certain enrollees who may no longer qualify for MA or MinnesotaCare between annual renewals. To maintain continuous coverage for enrollees, periodic data matching was suspended during the PHE. The 2021 MN legislature enacted a law to further suspend periodic data matching for up to six months following the end of the PHE. This proposal would set periodic data matching to resume after the unwinding of continuous coverage is complete. This is necessary to ensure we preserve continuous coverage for MA enrollees until their renewal is conducted, in accordance with the Consolidated Appropriations Act, 2022, and subsequent guidance from the Centers for Medicare & Medicaid Services (CMS).

Administrative Support
In order to conduct the largest enrollment undertaking that the state has seen since the implementation of the Affordable Care Act, DHS requests administrative resources to ensure that support to enrollees, counties, tribes, providers, managed care organizations, and other important stakeholders receive timely and accurate information and responses to inquiries.

To that end, DHS is requesting funding for additional temporary staffing, overtime for current staff, and contract dollars to support a contracted vendor and increased printing and postage needs over what would occur in a typical enrollment year.

Lead Agency Allocations
This proposal will allocate $36 million in grant funding to county and tribal processing entities for support for staffing and other administrative needs related to eligibility redeterminations during the unwinding period. Grant funds will be distributed to county and tribal processing entities based on the proportion of medical assistance enrollees whose eligibility they are responsible for redetermining. The agency will require one FTE (MAPE 14L) in the Financial Operations Division to manage this funding.

Impact on Children and Families:

MA enrollees who are age 65 or older, blind or who have disabilities who accrued assets above the MA limit during the COVID-19 PHE, would benefit by maintaining their health care coverage while having additional time to reduce these excess assets.

If this change is not enacted, some enrollees will lose MA due to excess assets after their continuous coverage ends. Once disenrolled, enrollees would spend their excess assets, and then reapply and be newly determined eligible for MA. This churn of enrollees off and back on MA will result in gaps in health care coverage and disruption in care, as well as confusion and stress for enrollees and their families who will need to quickly complete the application process to regain coverage.

If additional support for navigators is not enacted, some enrollees will lose MA or MinnesotaCare due to not successfully renewing. Once disenrolled, enrollees would seek out assistance from navigators to reapply and be newly determined eligible for MA or MinnesotaCare. This churn of enrollees off and back on MA or MinnesotaCare will result in gaps in health care coverage and disruption in care, as well as confusion and stress for enrollees and their families who will need to quickly complete the application process to regain coverage.

Equity and Inclusion:

The most important equity outcome related to resuming standard MA and MinnesotaCare eligibility policies and operations is the retention of all eligible people on the programs. Medical Assistance and MinnesotaCare cover the state's most vulnerable populations, including nearly 40% of the state's children. Additionally, 51.1% of African Americans and other Minnesotans of color get their health care through MHCP, compared to 34% of white Minnesotans.[1] One study noted that Black Medicaid enrollees were more likely than white enrollees to go off Medicaid for more than six months. Those who were off more than six months were less likely than those who stayed on to have a regular source of care, more likely to forego health care for financial reasons and more likely to report problems paying medical bills.[2] Strategies to help ensure eligible people remain enrolled will help Minnesotans who are BIPOC and other underserved populations retain vital access to health care services**.**

Based on the racial demographics of this population, this proposal would not disparately affect communities of color and indigenous people compared to whites. People enrolled in MA who are age 65 and older, blind or have a disability tend to be white (42% of current enrollees are white, versus 32% people of color or indigenous, with 26% "unknown"). However, the proportionate impact of accumulated assets is difficult to determine, because it is not possible to identify the exact enrollees who have or will obtain excess assets before redeterminations are conducted.

Navigators play a vital role in assisting Minnesotans who are subjected to persistent racial and class disparities with applying for Minnesota Health Care Programs and managing their health care cases. Navigators help mitigate multiple barriers to accessing health care coverage, including language and technology barriers, low health care literacy, difficulties understanding complicated processes and jargon, and more.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Tribal member enrollees who are age 65 or older, blind or who have disabilities who accrued assets above the Medical Assistance limit during the COVID-19 PHE, will benefit by maintaining their health care coverage while having additional time to reduce these excess assets during the unwinding period.

If this change is not enacted, some Medical Assistance enrollees who are age 65 or older, blind or who have disabilities will lose Medical Assistance due to excess assets. Once disenrolled, enrollees would likely spend their excess assets, and then reapply and be newly determined eligible for Medical Assistance. This will create an additional administrative burden for Tribal Nation eligibility workers in processing new applications.

Ensuring the Department has necessary resources and authority to give a best-faith effort in redetermining eligibility for Minnesotans enrolled in MHCP will have a significant impact on tribes, who process applications for MA and MinnesotaCare for their members. Supporting these activities through Navigator organizations, while reducing short-term barriers to enrollment, will ease the administrative burden on tribes during the unwinding process. Additionally, urban American Indian families would benefit from this support for navigators.

Impacts to Counties:

If this change is not enacted, some MA enrollees who are age 65 or older, blind or who have disabilities will lose MA due to excess assets. Once disenrolled, enrollees would likely spend their excess assets, and then reapply and be newly determined eligible for MA. This will create an additional administrative burden for the counties in responding to appeals, and in processing new applications.

Ensuring the Department has necessary resources and authority to redetermine eligibility for Minnesotans enrolled in MHCP will have a significant impact on counties, who process most applications for MA and MinnesotaCare. Supporting these activities through navigator organizations, while reducing short-term barriers to enrollment, will ease the administrative burden on counties during the COVID unwinding process.

IT Costs

This proposal contains funding for changes in the Minnesota Eligibility Technology System (METS), the Medicaid Management Information System (MMIS), and MAXIS to correspond with policy changes and to alleviate the need for manual processes.

Results:

The Department of Human Services expects this proposal will result in increased enrollment stability for MA and MinnesotaCare enrollees.

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of MA enrollees who have excess assets at renewal after the PHE ends. Counties will manually identify, track, and notify the MA enrollees who would be no longer eligible due to excess assets.	N/A		Unknown	Unknown	
Quality	MA enrollees maintain access to long term care and home- and community- based services and supports.	N/A		Unknown	Unknown	
Results	The number of MA enrollees who are able to appropriately reduce excess assets and remain eligible cannot be estimated at this time due to unavailability of relevant data.					

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY23	FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			0	57,490	1,064	58,553			
HCAF			0	10,265	0	10,265			
Federal TANF						0			
Other Fund						0			
Total All Funds			0	67,755	1,064	68,818			
Fund	**BACT#**	**Description**	**FY23**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	33ED	MA Grants		4,517		4,517			
HCAF	51	MinnesotaCare Grants		4,936		4,936			
HCAF	31	MinnesotaCare Grants		5,329		5,329			
GF	51	Grants to processing entities		36,000		36,000			
GF	13	HCA Admin - FTEs (111,6,0,0) plus overtime		12,267	463	12,730			
GF	13	HCA Admin - Contract, printing/mailing, paper		8,260	0	8,260			
GF	REV1	FFP@32%		(6,807)	(259)	(7,066)			
GF	11	HCA Admin - FTEs (5,5,0,0)		182	30	212			
GF	11	OPS Admin - (4,4,0,0)		500	483	983			
GF	11	OPS Admin - (5,5,0,0)		744	347	1,091			
GF	11	State share of systems costs		1,827	0	1,827			
		Requested FTE's							
Fund	**BACT#**	**Description**		**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	13	HCA FTEs		111	6				
GF	11	HCA and OPS FTEs		14	14				

Statutory Change(s):

N/A

Change Item Title: Improving Program Integrity in Minnesota Health Care Programs

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	971	1,038	1,038	1,038
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	971	1,038	1,038	1,038
FTEs	16	16	16	16

Recommendation:

The Governor recommends improvements to Medicaid provider screening, enrollment, and compliance to promote legal compliance; reduce wait times for provider screening, enrollment, and revalidation; enable the Department of Human Services (DHS) to respond to recent audit findings; and ensure state and federal Medicaid resources are apportioned to appropriate providers and Medicaid services. This proposal also includes funding to address disparities in access and quality of care for Medicaid enrollees. This proposal would require an investment of $2.0 million in FY 2024-25 and $2.1 million in FY 2026-27.

Rationale/Background:

Medicaid Provider Screening, Enrollment, and Compliance

The DHS Medicaid provider screening, enrollment and compliance function ensures that providers participating in Medical Assistance and MinnesotaCare are properly licensed and insured and is critical to the Department's efforts to identify and prevent fraud. When fully resourced, this function can promptly identify and mitigate risks and ensure that these risks are monitored over time. The demands of this work have grown beyond current staffing capacity, which has contributed to an increase in audit findings and a growing risk of over- or underpayments to enrolled providers. This has also resulted in increased processing times for providers as they attempt to enroll in the MA and MinnesotaCare programs.

Over the past decade, the passage of the federal Affordable Care Act and the 21st Century Cures Act, alongside a variety of changes to Minnesota state laws aimed at addressing program integrity, have fundamentally changed the scope and volume necessary to maintain the integrity of Medicaid provider screening, enrollment and compliance. For example, since 2009, DHS has enrolled over 180,000 individual personal care attendants (PCAs), each of whom must be rescreened and re-enrolled (e.g., "revalidated") every three years; initial estimates and resources identified for this purpose assumed that enrollment would only reach 7,000 individual PCAs. Federal law also now requires DHS to revalidate every enrolled Medicaid provider every five years and to screen and enroll an estimated 80,000 additional providers that are part of the networks used by contracted managed care organizations (MCOs). These new regulations have increased the complexity of the work and more than doubled the number of providers being screened, enrolled, and monitored for compliance annually by DHS.

To meet some of these demands and enable a degree of provider self-service, DHS launched Phase 1 of Minnesota's Provider Screening and Enrollment (MPSE) application in July of 2019. This online portal enables providers to initiate their enrollment and revalidation and enable them to update their licensing information. MPSE creates efficiencies in the process but does not fully offset the increased volume in work. Future phases of MPSE will automate some verifications against federally required databases and help reduce delays in processing

and the need to retroactively recover payment when a credential or license expires. MPSE will continue to reduce processing time but will never fully eliminate the manual work necessary to adequately screen and enroll providers and does not address the significant increase in volume of providers enrolling with DHS.

The existing team of FTEs currently has the capacity to process an average of 10,200 provider applications each month but is required to manage over 18,000 applications. This discrepancy presents risks in DHS compliance with many requirements, including license reports, Office of the Inspector General/System for Award Management (SAM) database checks, provider enrollment terminations performed by CMS and other states' Medicaid programs, and MCO in-network provider enrollment. It also means that over 8,000 activities are not being processed in a timely manner or at all, creating longer wait times, and putting the state at risk of audit findings and federal match penalties.

Project ECHO to Reduce Health Disparities

Besides provider screening, enrollment, revalidation, and compliance, the Department also offers providers who are enrolled in Minnesota Health Care Programs training to help ensure that all recipients of health care services in these programs can access quality care. One important mechanism through which the Department supports MHCP providers through ECHO training resources. ECHO's utilize training methods used in clinical training to support clinical professionals to continue to develop and address complex areas of practice. DHS has already established ECHOs to support providers in efforts to improve prescribing practices for patients with opioid use disorder. A 2021 MMB Results First evaluation concluded that ECHO was proven to be effective at improving prescribing practices.[1]

BIPOC enrollees in MHCP experience significant challenges in finding and accessing appropriate, high-quality care that is culturally appropriate. These challenges contribute to health disparities observed in Minnesota among BIPOC enrollees compared to their white counterparts. Provider training is a critical tool to help address this problem and to help close gaps in health outcomes.

Proposal:

This proposal will invest in provider enrollment to adequately staff this function, which will improve processing times for provider screening, enrollment and revalidation, improve the timeliness of enforcement action, and, ultimately, reduce the likelihood of DHS needing to take corrective actions toward providers. While MPSE enables providers to enter and track their applications and update their licenses, the function of provider screening, enrollment, and ongoing compliance continues to be a labor-intensive process as each provider's certifications, background studies, and other similar documentation must be submitted to and reviewed by DHS.

Current obligations for the provider enrollment team amount to 171,900 processing requests annually, including over 200 individual PCA applications per day. By adding 16 FTEs (a 50 percent increase in staffing), DHS anticipates increasing its processing capacity by approximately 48,000 requests annually (an over 50 percent increase) and meeting the current volume of processing requests and additional work items.

This proposal also includes funding to expand Minnesota's Project ECHO program to include conditions beyond opioid use disorder. Project ECHO is a virtual learning environment designed to help clinical professionals learn about how they can improve their practices from other clinical professionals. By expanding Project ECHO, DHS will be able to deploy a clinical training model to providers from across the state and from diverse fields of practice. The topics that will be addressed will be identified in partnership with patients so that this work is targeted to support and improve patient's health with a specific focus on interventions that will reduce health disparities. Expanding Project ECHO to three new hubs would cost approximately $650 thousand annually. These expenses

[1] Minnesota Management & Budget, Evaluation of ECHO Programs in Minnesota, 8/20/2021, available at https://www.lrl.mn.gov/docs/2021/mandated/210878.pdf.

would fund the clinical support to host the ECHO's and funds to conduct community outreach to ensure the topics are targeted to address the most pressing health disparities.

Impact on Children and Families:

This proposal would ensure that children and families served by Medical Assistance and MinnesotaCare receive services from providers who are compliant, appropriately vetted, and tracked. These policies aim to ensure that our members receive appropriate, high quality health care services from screened and enrolled providers.

With funding for new Project ECHO hubs, quality and access to care for children and families in BIPOC communities will improve.

Equity and Inclusion:

Timely provider screening and enrollment ensures that providers can submit claims for the correct client, for the correct amount, at the correct time and get paid quickly and accurately. This means that providers will be more willing to serve individuals on Medical Assistance and MinnesotaCare. The clarity in enforcement of the policy manual also removes any ambiguity about the application of those policies.

With funding for new Project ECHO hubs, quality and access to care for enrollees in BIPOC communities will improve.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:

This proposal does not directly impact counties.

IT Costs

No IT costs are associated with this proposal.

Results:

DHS assumes this proposal will increase processing volume by 48,000 requests annually. This will improve the processing times providers currently experience, ensuring they are ready to serve MHCP members.

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Annual new enrollments	70,529	2021			Annual
Quality	Providers enrolled in MHCP	313,822	2021			Annual
Quantity	Providers attending Project ECHO hub sessions	N/A	2022			Annual
Quality	Patient outcome measures	N/A	2022	Unknown		Annual

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			971	1,038	2,009	1,038	1,038	2,076
HCAF								
Federal TANF								
Other Fund								
Total All Funds			971	1,038	2,009	1,038	1,038	2,076
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	HCA Admin - FTEs (16,16,16,16)	529	596	1,125	596	596	1,192
GF	13	HCA Admin - Contract	650	650	1,300	650	650	1,300
GF	REV1	FFP @ 32%	(208)	(208)	(416)	(208)	(208)	(416)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	HCA Admin - FTEs (16,16,16,16)	16	16		16	16	

Change Item Title: Continued Improvements to Access to Oral Health

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	6,175	14,678	16,325	18,634
Revenues	0	0	0	0
Other Funds				
Expenditures	2,796	6,387	7,087	7,831
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	8,971	21,065	23,412	24,465
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends additional investments in oral health for individuals enrolled in Minnesota Health Care Programs (MHCP), including reinstating the adult dental benefit and rebasing dental rates to more accurately reflect the cost of providing dental care. This proposal requests an investment of $30,036,000 in the FY2024-2025 biennium and $49,877,000 in the FY2026-2027 biennium.

Rationale/Background:

Medical Assistance and MinnesotaCare have had dental access issues for decades. Several changes were made in 2021 to improve public program enrollee access to dental benefits, but more work is needed. Without dental coverage, people access care in the emergency room and are often prescribed drugs to manage pain without resolution of the underlying dental issue. Dental health is known to contribute to overall physical health and well-being.

In 2008, the legislature reduced services covered in the adult dental benefit set due to a state budget deficit. As a result of that change, many adults who have medically necessary dental needs cannot get appropriate care. This lack of a comprehensive benefit has been mentioned by providers as a disincentive to participate in the program because they either must provide inadequate care to patients or provide care without reimbursement. Dental access rates for adults are considerably lower than access rates for children, who are currently able to access a comprehensive benefit set.

Secondly, although rates were increased in 2021 and the methodology was simplified, dental rates are still based on information on the cost of delivering care from 1989. The practice of dentistry has greatly evolved in 33 years as the cost of technology and staff have changed. This proposal would allow DHS to rebase the dental rates so they more accurately reflect today's cost of treatment. The rebase would be performed every three years and would include an inflationary adjustment to prevent dental rates for public programs becoming outdated as they have in the past.

Proposal:

This proposal would make two improvements to the dental benefit in Medical Assistance and MinnesotaCare. First, it would reinstate the comprehensive adult benefit set, similar to the benefit set currently offered for children, effective January 1, 2024. Second, it would rebase rates paid for dental services to ensure that dental rates do not remain stagnant and reflect the cost of delivering care today and in the future.

Forecast impacts
MA adults were last covered by a full dental benefit set in 2009. Based on department data from CY2009 and CY2010, it is estimated that moving from the current limited dental benefit set to a full benefit set for adults in MA and MinnesotaCare would result in a 36.5% increase over current dental costs for this population, which is estimated at over 800,000 enrollees. It is further estimated that 54% of current MA dental payments are for adults; this proportion is assumed to also apply in current law forecast projections.

Administrative impacts
DHS will require a $25,000 per FY contract amendment with the state's prior authorization vendor to recognize additional prior authorization requests due to this proposal. Federal Financial Participation (FFP) is estimated at 32%.

Impact on Children and Families:
Having sustainable access to oral health is important for overall health. While children enrolled in MHCP already have access to comprehensive dental care, this proposal will expand the dental benefit so that all MHCP enrollees have access to a comprehensive benefit set. Without dental coverage, people access care in the emergency room and are often prescribed drugs to manage pain without resolution of the underlying dental issue. Dental health is known to contribute to overall physical health and well-being. In addition, it rebases dental rates so that payment is more reflective of the costs of services today. Although there have been improvements in the MHCP oral health program, there are still several disincentives that discourage dental providers from participation in public programs. All MHCP enrollees benefit when providers are paid accurate rates.

Equity and Inclusion:
Continued investments in dental access will have positive impacts for Minnesota Health Care Program enrollees. Currently, 1 in 4 Minnesotans is enrolled in MHCP. This proposal expands the dental benefit for adults so that all enrollees will have access to a comprehensive set of dental services. Without dental coverage, people access care in the emergency room and are often prescribed drugs to manage pain without resolution of the underlying dental issue. Dental health is known to contribute to overall physical health and well-being. In addition, it rebases dental rates so that payment is more reflective of the costs of services today. All MHCP enrollees benefit when providers are paid fair rates.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
This proposal does not directly impact counties.

IT Costs
IT systems changes would be required to implement this change in the Medicaid Management Information System, MMIS, which is Minnesota's automated system for payment of medical claims and capitation payments for the Medical Assistance and MinnesotaCare programs. These systems changes are estimated to require 419 hours of work, take approximately 3 months to complete, and cost a total of $41,481 for initial development. State share is assumed at 29%. This estimate includes the following assumptions:

1. The estimated duration and earliest completion date of the proposed project(s) assumes the work is prioritized relative to other legislative and ongoing IT work. If enacted, the completion date of the proposed project(s) will be dependent on the totality of enacted legislative IT work and ongoing IT work.
2. The total hours assumed in this fiscal note include the projected time required to complete systems work and a 20% contingency assumption to account for unforeseen business requirements in the development and implementation process.
3. In addition to the initial development costs cited above, the systems changes required in this bill will result in increased ongoing maintenance and operations costs, estimated annually at 20% of the total initial development cost.

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Access to Dental Care	39%	2019	TBD	TBD	Annual

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
General Fund			6,175	14,678	20,853	16,325	18,634	34,959
HCAF			2,796	6,387	9,183	7,087	7,831	14,918
Federal TANF								
Other Fund								
Total All Funds			8,971	21,065	30,036	23,412	26,465	49,877
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	33ED	MA Grants	2,435	5,863	8,298	6,589	7,268	13,857
GF	33AD	MA Grants	1,557	3,499	5,056	3,869	4,184	8,053
GF	33FC	MA Grants	2,162	5,297	7,459	5,848	7,163	13,011
HCAF	31	MinnesotaCare Grants	2,796	6,387	9,183	7,087	7,831	14,918
GF	13	HCA Admin - Contract	13	25	38	25	25	50
GF	REV1	FFP @ 32%	(4)	(8)	(12)	(8)	(8)	(16)
GF	11	State Share of Systems Costs (MMIS)	12	2	14	2	2	4
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

Minnesota Statutes, section 256B.0625, subd. 9
Minnesota Statutes, section 256B.76

Change Item Title: Remove Doula Supervision Requirements

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	33	40	40	40
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	33	40	40	40
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends $33 thousand in FY 2024 and $40 thousand each year thereafter to remove the requirement of supervision by a licensed provider for doula services in Minnesota's Health Care Programs (MHCP) in order to increase access to services that help reduce maternal and infant health disparities. Doula care has been associated with reduced preterm birth, reduced C-section rate, improved feelings about childbirth, and decreased use of pain medication.

Rationale/Background:

One of the barriers to development of a doula workforce that adequately serves Minnesota's public program enrollees, cited by both community members and health policy literature, is the requirement that doulas operate under the supervision of a licensed health care professional to bill MA for their services. This supervision has not shown to provide any additional clinical benefit and practicing doulas have consistently cited this requirement as a barrier.[1] Removing this barrier will help increase doulas working with Minnesota's public program enrollees, as well as impact some of the state's geographic disparities.

Members of the Minnesota Healing Justice Network, as well as grantees within DHS' Integrated Care for High-Risk Pregnancies (ICHRP) program and leading public health researchers at the University of Minnesota School of Public Health, have brought this issue to the Department of Human Services (DHS) at different times over the last several years. The licensed supervisor issue has been cited as a reason that doulas struggle to provide services to MHCP enrollees or sustain services if able to navigate the process initially.

Increasing access to this service will benefit all pregnant MHCP enrollees, but it is particularly notable that MHCP serves eight out of 10 Black birthing persons and nine out of 10 Native birthing persons. Increasing access to doulas can help reduce maternal and infant health disparities given doula care has been associated with reduced preterm birth, reduced C-section rate, improved feelings about childbirth and decreased use of pain medication.

Minnesota is one of only a handful of states that offers doula services through its Medicaid benefit. Oregon was the first state to offer doula services through Medicaid, and they do not require doulas practice under the

[1] Nguyen, Ashley. "Doula Work is 'taxing' with little pay. Can Minnesota make it more sustainable?" *Washington Post, March 1, 2021.* Available at https://www.washingtonpost.com/graphics/2021/the-lily/using-a-doula-minnesota/.

supervision of a licensed provider.[2] Minnesota has garnered national recognition[3] for its doula benefit while also having it noted that barriers remain.[1] This proposal seeks to remedy one of those noted barriers.

Proposal:
This proposal will remove the requirement of supervision for practicing doulas by a licensed provider. Doula agencies will be able to enroll and be reimbursed directly.

Because doula services are support services and are not meant to take the place of obstetric care, DHS does not expect any impacts on clinical effectiveness or patient safety. Anecdotal information provided to DHS has identified that current supervision requirements are often met by licensed providers who have not been trained as doulas.

To calculate program costs, DHS estimated that removal of the supervision requirement will result in an overall claims utilization increase of 50 percent.

Impact on Children and Families:
Doulas have been identified by a several public and private agencies as an underutilized resource that can help address maternal and infant health. This policy aligns with that understanding and will be one way the Department can help improve the doula workforce, in particular those that work with MHCP enrollees.

Doulas work with mothers, birthing persons, and families, both prenatally and after the child's arrival. This is a particularly critical window for bonding, brain development, and receptiveness to parenting skills coaching which not only provide a healthy start but can have long lasting impacts.

Doula care has been associated with reduced preterm birth, reduced C-section rate, improved feelings about childbirth, and decreased use of pain medication. These outcomes can not only reduce costs short term but less preterm birth and decreased use of pain medication can have long term cost and health benefits that will then be shared by all Minnesotans.

Equity and Inclusion:
MHCPs serve eight out of 10 Black birthing persons and nine out of 10 Native birthing persons. Given that doula care has been associated with reduced preterm birth, reduced C-section rate, improved feelings about childbirth and decreased use of pain medication, increasing access to doula services can help reduce maternal and infant health disparities. However, because of the potential for a decreased connection between doulas and other medical providers, extra efforts may be necessary to educate enrollees that doula care is supplemental to, but not a replacement for, medical obstetric care.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
This proposal has no direct impact on counties.

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[2] Oregon State Plan Amendment, SPA #17-0006. Available at https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OR/OR-17-0006.pdf.
[3] Platt, Taylor & Kaye, N. "Four State Strategies to Employ Doulas to Improve Maternal Health and Birth Outcomes in Medicaid" National Academy for State Health Policy, July 2020. Available at https://www.nashp.org/wp-content/uploads/2020/07/Doula-Brief-7.6.2020.pdf.

IT Costs

Total systems costs for this proposal are estimated at $66,231 for initial development. Ongoing costs are estimated at 20 percent and the state share is estimated at 29 percent.

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of individually enrolled doulas	0	Sept 2022	0	Unknown	
Results	Increased utilization of doula services via claims data analysis					

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
General Fund			33	40	73	40	40	80
HCAF								
Federal TANF								
Other Fund								
Total All Funds			33	40	73	40	40	80
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	33FC	MA Grants	14	36	50	36	36	72
GF	11	State Share of Systems Costs	19	4	23	4	4	8
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

Minnesota Statutes, section 256B.0625, subd. 28b

Change Item Title: Elimination of Medical Assistance Cost-sharing

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	3,051	6,156	6,546	6,874
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	3,051	6,156	6,546	6,874
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends eliminating all cost-sharing in the Medical Assistance (MA) program. This proposal would require an investment of $9,207,000 in FY24-25 and $13,420,000 in FY26-27.

Rationale/Background:

Some Medical Assistance (MA) enrollees are subject to cost-sharing, including copays and deductibles. Certain enrollees, as outlined below, do not have copays or family deductibles for medical services:

- Members who are pregnant women;
- Members under age 21;
- Members receiving hospice care, and;
- Members living in a nursing home, hospital, or other long-term care facility for more than 30 days.

Many services, including emergency services, family planning services, mental health services, preventive care visits, some mental health drugs, and medical transportation, do not have copays or family deductibles applied to them.

For those enrollees who are subject to copays, the following amounts apply:

- $3 for nonpreventive visits, with an exception for mental health visits;
- $3.50 for nonemergency visits to a hospital-based emergency room;
- $3 per brand name drug prescription;
- $1 for each generic drug prescription; and
- $1 per prescription for brand name multi-source drugs listed in preferred status on the Preferred Drug List (PDL)

Copayments are capped at $12 per month for prescription drugs.

Families on MA are also subject to a deductible, which is an amount that adult family members must pay each month toward health care costs. The deductible is separate from the copay, and as of calendar year 2022, was $3.55 per month. This amount is adjusted yearly.

The complexity in copayment policy is confusing for enrollees and providers alike. Providers, who are responsible for collecting copays and deductibles, are not able to withhold services from an MA enrollee if they are unable to pay, effectively resulting in a rate cut for providers when treating an enrollee who is unable to contribute to the cost of service.

Proposal:

This proposal will eliminate all cost-sharing in the Medical Assistance program and is assumed to be effective January 1, 2024.

Forecast impacts

The fiscal impact of this proposal is to shift the obligation of all current cost-sharing from the enrollee to the state. This can be estimated as a straight shift of cost within the program, increasing state-obligated medical costs in MA.

Based on department data, the value of annual cost-sharing in MA fee-for-service (FFS) is equivalent to about 0.15% of current FFS basic care payments. (This percentage varies slightly between eligibility populations.) It is assumed that these proportions are the same for enrollees in MA Managed Care.

As a result of this change, state-funded MA payments are expected to increase.

Administrative impacts

As cost-sharing is currently collected by providers, there is no administrative impact to DHS as a result of this change.

Impact on Children and Families:

All MA enrollees will no longer be subject to copays or deductibles. While children and pregnant women are currently excluded from having copays, elimination of this cost-sharing requirement will allow families with other members enrolled in MA to use those funds for other needs.

Equity and Inclusion:

Low-income and underrepresented populations are disproportionally enrolled in MA as compared to commercial insurance. For many families, the amounts of copays and deductibles can add up to be a significant financial burden. Eliminating a barrier to accessing health care will help improve the lives of all MA enrollees.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:

This proposal does not directly impact counties.

IT Costs

IT systems changes would be required to implement this change in the Medicaid Management Information System, MMIS, which is Minnesota's automated system for payment of medical claims and capitation payments for the Medical Assistance and MinnesotaCare programs. These systems changes are estimated to require 528 hours of work, take approximately 2 months to complete, and cost a total of $52,272 for initial development. State share is assumed at 29%. This estimate includes the following assumptions:

1. The estimated duration and earliest completion date of the proposed project(s) assumes the work is prioritized relative to other legislative and ongoing IT work. If enacted, the completion date of the proposed project(s) will be dependent on the totality of enacted legislative IT work and ongoing IT work.
2. The total hours assumed in this fiscal note include the projected time required to complete systems work and a 20% contingency assumption to account for unforeseen business requirements in the development and implementation process.
3. In addition to the initial development costs cited above, the systems changes required in this bill will result in increased ongoing maintenance and operations costs, estimated annually at 20% of the total initial development cost.

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of claims paid for enrollees for services previously subject to copays	843,201	SFY 2021	850,000	0	SFY 2024
Quality	Number of reports of unpaid copays from providers				0	
Results	Average number of claims per member for services subject to a copay before and after the change	7,244,647	SFY 2021	7,250,000	7,606,879	SF Y2024

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			3,051	6,156	9,207	6,546	6,874	13,420
HCAF								
Federal TANF								
Other Fund								
Total All Funds			3,051	6,156	9,207	6,546	6,874	13,420
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	33ED	MA Grants	1,998	4,156	6,154	4,481	4,757	9,238
GF	33AD	MA Grants	230	425	655	438	451	889
GF	33FC	MA Grants	808	1,572	2,380	1,624	1,663	3,287
GF	11	State share of systems costs	15	3	18	3	3	6
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

Minnesota Statutes, section 256B.0631

Change Item Title: Medical Assistance – Employed Persons with Disabilities Program Improvements and Conforming Changes

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	208	42	42	42
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	208	42	42	42
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends streamlining the Medical Assistance for Employed Persons with Disabilities (MA-EPD) program and making changes to conform with federal law. This proposal requires an investment of $250 thousand in FY 2024-25 and $84 thousand in FY 2026-27.

Rationale/Background:

This proposal seeks to streamline the administration of Medical Assistance for Employed Persons with Disabilities (MA-EPD) and to conform the program to federal law requirements.

Currently, county and tribal agencies determine MA-EPD eligibility and collect initial premiums. DHS establishes the enrollee's financial account, credits initial premiums, and bills and collects ongoing premiums through the Statewide Integrated Financial Tools (SWIFT) system. SWIFT, the billing system, is not connected to MAXIS, the eligibility system. County and tribal financial eligibility workers do not have access to SWIFT. Because of this disconnect between SWIFT and MAXIS, multiple communications and hand-offs are required between county and tribal agencies and DHS in order to administer premium billing. This often causes confusion for enrollees and, in some cases, results in gaps in MA-EPD eligibility or health care coverage due to errors from manual work.

The MA-EPD statute also contains some disagreement with federal law. Certain elements of the MA-EPD program passed into state law (Minn. Stat. Section 256B.056) in 2012 do not comply with federal regulations that require comparability, that is, the comparable treatment of similarly situated people, within MA. The state law allows for a disregard of spousal income and assets when MA eligibility is determined for a person aged 65 or older when that person is a former MA-EPD enrollee who no longer meets the earned income requirements for the program. However, this disregard is not permitted for other people who are being determined for MA as persons who are age 65 or older. A DHS appeal to CMS on this matter was ultimately resolved in CMS's favor in March 2022.

Finally, Minnesota Statutes currently contain no explicit authority enabling DHS to make adjustments when premiums have been charged in error. This has caused administrative and financial complications as well as problems for enrollees. The billing system applies payments to the oldest unpaid month, so it is necessary to zero out premiums that have been charged in error.

Proposal:

First, this proposal improves the MA-EPD premium billing system by moving the process from the Statewide Integrated Financial Tools (SWIFT) system to the Medicaid Management Information System (MMIS), therein reducing the manual work that is now required of counties and tribal agencies to collect premiums. With premium billing in MMIS, eligibility workers will be able to enter information and view premium payments in MMIS, and will not have to rely on DHS to create financial accounts. Transferring the premium billing functionality from SWIFT to MMIS will improve enrollee access to MA-EPD and remove the manual hand-off needed for the current SWIFT billing process.

Second, this proposal makes conforming state law changes that are needed as a result of a years'-long appeal over a Medicaid State Plan Amendment (SPA) disapproved by CMS. The appeal resolved the issue in CMS's favor, concluding that MA-EPD policy based on Minnesota Statutes section 256B.056 violates Medicaid comparability requirements. This proposal would remove the 2012 changes to statute that violate comparability and never received federal approval.

Finally, this proposal includes a provision granting the commissioner of DHS the authority to determine that premiums have been charged in error and to make corrections. The fiscal impact for this provision is indeterminable but is likely small.

Impact on Children and Families:

Improving the MA-EPD premium billing system will decrease the number of MA-EPD enrollees who experience coverage gaps because of misunderstandings related to premium billing and payment. Furthermore, moving the billing system to MMIS allows enrollees to have more information, such as credits, past-due amounts, and premiums for past months, visible on premium notices.

Equity and Inclusion:

MA-EPD is a program for people with disabilities who may not otherwise qualify for Medical Assistance. By making beneficial changes to the MA-EPD premium billing system, this proposal increases equitable access to MA-EPD.

Conforming state law to Medicaid comparability requirements will adversely impact people with disabilities, particularly current MA-EPD enrollees who wish to end work or retire (thus moving off MA-EPD) and former MA-EPD enrollees who have depended upon spousal disregards to maintain MA eligibility in the elderly category.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Improving the MA-EPD premium billing system will reduce the complexity of the billing process and ease the resource commitment for DHS and county and tribal nation processing entities by automating manual work. Making conforming changes to state law in light of the MA-EPD SPA decision will require additional work by DHS which must communicate the change and its implications to county and tribal partners and other stakeholders. Processing entities will be required to redetermine eligibility without the benefit of the aforementioned disregards. Since the proposed conforming change to state law represents has an adverse impact on MA-EPD enrollees, it is likely there will be additional public assistance appeals.

Impacts to Counties:

Improving the MA-EPD premium billing system will reduce the complexity of the billing process and ease the resource commitment for DHS and county and tribal nation processing entities by automating manual work. This part of the proposal was developed to address concerns that have been raised to DHS by county and tribal agencies and advocates for people with disabilities. These partners are supportive of this proposal as it will streamline MA-EPD billing and reduce administrative burden.

In the current process, counties and tribes are responsible for the following steps: (1) determining the MA-EPD eligibility and premium amount; (2) mailing the initial premium invoice to collect premium payments for any retroactive months, the current month, and the next month; (3) receiving the premium payment; (4) manually opening MMIS coverage; (5) mailing the premiums to DHS-FOD; (6) communicating, via email, to DHS's Billing Team to create a new billing account or reopen an existing account. The proposed change to move billing from SWIFT to MMIS will remove steps (2) - (5) from counties and tribes.

Making conforming changes to state law in light of the MA-EPD SPA decision will require additional work by DHS which must communicate the change and its implications to county and tribal partners and other stakeholders. Processing entities will be required to redetermine eligibility without the benefit of the aforementioned disregards. Since the proposed conforming change to state law represents has an adverse impact on MA-EPD enrollees, it is likely there will be additional public assistance appeals.

IT Costs

Systems impacts as a result of this proposal will total an estimated $630,693 in total dollars. Ongoing costs are estimated at 20 percent. State share is estimated at 55 percent for MAXIS, 29 percent for MMIS, and 50 percent for all other impacted systems.

Results:

DHS expects that enrollees and stakeholders will report improved experience with MA-EPD premium billing as a result of changes to the billing process. Automating the billing process will decrease phone calls to workers and decrease work by the HCEO billing unit, also decrease the number of premium waivers required due to less agency error.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			208	42	250	42	42	84
HCAF					0			0
Federal TANF					0			0
Other Fund					0			0
Total All Funds			208	42	250	42	42	84
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	State Share of Systems Costs	208	42	250	42	42	84
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

Minnesota Statutes, section 256B.056, subd. 3a, paragraph (6)

Change Item Title: Newborn Screening Fee Increase Technical Fix

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	3	4	4	5
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	3	4	4	5
FTEs	**0**	**0**	**0**	**0**

Recommendation:
The Governor recommends modifying Medical Assistance (MA) payment methodologies to allow payment for newborn screening at the Minnesota Department of Health when the screening is provided in outpatient settings. This proposal would require an investment of $7 thousand in FY 2024-25 and $9 thousand in FY 2026-27.

Rationale/Background:
The 2021 Legislature passed an increase in the newborn screening fee charged by the Minnesota Department of Health (MDH). In the Medical Assistance (MA) program, the rate for inpatient hospital services in fee-for-service accounts for the cost of this test, so the Department of Human Services adjusted the inpatient hospital payment rate accordingly.

However, there are scenarios in which a newborn screening test may be billed in an outpatient setting because there is not an inpatient hospital stay (for example, during a home birth). In implementing the newborn screening fee change, DHS identified a lack of authority to pay the MDH rate for newborn screening when the test is billed in an outpatient setting. This proposal would give DHS authority to reimburse outpatient claims when appropriate.

Proposal:
This proposal provides DHS with additional authority to reimburse providers for MDH newborn screening in outpatient settings. According to DHS data, there were fewer than 50 recipients who received the newborn screening service in outpatient settings in SFY2021. The effective date of this proposal is July 1, 2023.

Impact on Children and Families:
This proposal ensures that all providers are paid the same rate for providing newborn screening. All enrollees are best served when payment is appropriate to the services rendered and sufficient to ensure access to the services.

Equity and Inclusion:
This proposal ensures that all providers are paid the same rate for providing newborn screening regardless of where the service is delivered. All enrollees are best served when payment is appropriate to the services rendered and sufficient to ensure access to the services.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:

This proposal has no direct impact on counties.

IT Costs

This proposal does not have any IT related needs.

Results:

DHS does not operate the screening program. This proposal provides DHS explicit authority to ensure that the cost of the screening is reimbursed when it is performed outside of a hospital setting. Current statute provides specific authority for DHS to reimburse hospitals for the cost of the screening. In addition, because reimbursements to freestanding birth centers are derived from inpatient hospital rates, the cost of the screening is accounted for in the birth center setting. This may have been deemed sufficient given that the vast majority of births take place in an inpatient hospital or birth center setting. This change will clarify that DHS has authority to reimburse providers for the cost of the screening when the test sample cannot be collected by a hospital or birth center either because the birth did not take place in a hospital birth center or when the health of the newborn makes it medically inappropriate to collect the sample before the newborn is discharged home from a hospital setting.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			3	4	7	4	5	9
HCAF								
Federal TANF								
Other Fund								
Total All Funds			3	4	7	4	5	9
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	33FC	MA Grants	3	4	7	4	5	9
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

Minnesota Statutes, section 256B.76

Change Item Title: Ensuring Access to Health Care Services

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	2,275	5,373	5,771	5,694
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	2,275	5,373	5,771	5,694
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends implementing a 12% rate increase for NEMT modes 3-5, a fuel adjuster for rates that responds to changes in gas prices, modifying program documentation standards for non-emergency medical transportation (NEMT) and increasing per diem rates for meals and lodging. This proposal recommends an investment of $7,648,000 in the FY2024-2025 biennium and $11,465,000 in the FY2026-2027 biennium.

Rationale/Background:

The Medical Assistance and MinnesotaCare programs cover seven different modes of transportation within the Non-Emergency Medical Transportation (NEMT) benefit in an effort to reduce cases in which transportation is a barrier to accessing medical care. Members are matched with the mode of transportation that best meets their transportation needs, considering availability of providers, as well as any of the enrollee's physical or cognitive factors. Members receive the most cost-effective, appropriate transportation option that will best meet their needs.

Over the past year, the Department of Human Services (DHS) has heard from NEMT providers about the challenges of managing the costs of transportation. Part of this challenge is due to the level of base and mileage rates paid to NEMT providers, and part of it is due to the unpredictable fluctuation in fuel costs. Currently, the rates paid to NEMT providers do not consider when fuel costs change, which is especially difficult when gas prices fluctuate as drastically as they did during 2022.

Additionally, counties with limited health care facilities, such as birth services, can require between 14-110 miles to the next nearest facility. As hospital systems regionalize their services, such as obstetric services, and relocate labor and delivery, or as small hospitals close this service completely, rural residents will be forced to drive farther and farther to access care.

Minnesota Health Care programs cover non-emergency transportation up to 30 miles for primary care and 60 miles for specialty care. Longer distances can be covered but these trips require additional authorization. Services must be coordinated through the county or tribal services. Ancillary transportation costs include lodging at $50.00 per night is allowed unless prior authorized by the local agency for a higher rate and meals, including breakfast reimbursement limit, $5.50 per authorized person; lunch reimbursement limit, $6.50 per authorized person; dinner reimbursement limit, $8.00 per authorized person. When appropriate, expenses for the member and one responsible person or volunteer driver are eligible for reimbursement.

Proposal:

This proposal would increase base and mileage rates for NEMT modes 3-5, the most used modes of NEMT, by 12%. This proposal would also establish a fuel adjuster for Nonemergency Medical Transportation (NEMT). The fuel adjuster would allow DHS to incrementally adjust rates paid for NEMT services up and down as fuel costs fluctuate, which is a major input into the costs of transportation providers. Secondly, this proposal would adjust the documentation standards for NEMT providers when delivering services to make them less burdensome while maintaining program integrity.

The fuel adjuster would apply to NEMT rates when the average price of gas at the pump over all grades is above $3 per gallon and is assumed to have an effective date of January 1, 2024. The adjustment (when prices exceed the $3 threshold) is one percent for every 10-cent increase or decrease in the price of gas. DHS will make rate adjustments each quarter.

Based on department data from CY2019, it is estimated that every one percent increase in the current mileage rate would result in a 0.67% increase in overall NEMT payments. Based on data and projections from the US Energy Information Administration (EIA), Midwest gas prices are expected to remain above $3 per gallon through CY2023. Average gas prices and corresponding percent increases in NEMT expenditures are projected as follows:

	Avg. Gas Prices per Gallon	% Increase in Mileage Rates	% Increase in Overall NEMT
SFY2023	$3.50	5.00%	3.33%
SFY2024	$3.10	1.00%	0.67%
SFY2025	$3.00	0.00%	0.00%

The increase in NEMT mileage rates associated with these fuel adjustments are also expected to have a proportional impact on managed care rates. Based on prior fiscal note data, it is assumed that approximately one percent of managed care payments are for NEMT services. Only an impact to MA is accounted for in this fiscal estimate; the corresponding impact to MinnesotaCare managed care rates is estimated to be immaterial to setting overall rates for that program.

DHS estimates that a contract amendment with the DHS actuary will be needed to account for mid-year rate adjustments in managed care contracts due to the fuel adjuster. The value of this contract amendment is estimated at $25,000 per fiscal year and is assumed to draw down 32% Federal Financial Participation (FFP).

This proposal also increases the maximum per diem rates/reimbursements for meals and lodging when enrollees need to travel in order to receive care. For meals, the maximum per diem rate for breakfast will be increased by 64%, the maximum per diem rate for lunch will be increased by 69%, and the maximum per diem rate for dinner will be increased by 100%, mirror those used for state employees. The maximum reimbursement rate for lodging will be increased by 96%.

Finally, this proposal would adjust the documentation standards for NEMT providers when delivering services to make them less burdensome while maintaining program integrity. Through preliminary audits of the NEMT program, DHS has determined that the NEMT documentation standards are overly prescriptive. This proposal would allow providers to submit information for sufficient determination by DHS that the ride occurred, was documented appropriately, and ensured the health and safety of the client, without being overly punitive for administrative errors made by providers.

Impact on Children and Families:
NEMT is specifically used for those who are not able to transport themselves. Ensuring access to this service makes it possible for enrollees without personal transportation access to receive needed medical care. Many enrollees who use NEMT do not have other alternatives for transportation to medical services. Without the availability of NEMT services, enrollees may forgo necessary care, resulting in higher needs later.

Equity and Inclusion:
Ensuring access to this service makes it possible for enrollees to receive needed medical care. Many enrollees who use NEMT do not have other alternatives for transportation to medical services. Additionally, due to the longer distances traveled to reach care in greater Minnesota, members outside of the metro area are disproportionally impacted by provider shortages due to sudden changes in fuel prices.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
Counties administer part of the NEMT program for the MA fee-for-service program. When operating costs increase suddenly, counties have reported difficulties in ensuring consistent access to providers who are able to meet the needs of their communities.

IT Costs
There are no systems impacts as a result of this proposal. Fuel price adjustments will be manually input into the Medicaid Management Input System (MMIS).

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of NEMT rides provided	7.177m	FY2021	6.818m	7.2m	FY2023
Quality						
Results	Number of complaints received by enrollees for lack of access					

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			2,275	5,373	7,648	5,771	5,694	11,465
HCAF								
Federal TANF								
Other Fund								
Total All Funds			2,275	5,373	7,648	5,771	5,694	11,465
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	33ED	MA Grants	561	1,089	1,650	1,285	1,317	2,602
GF	33AD	MA Grants	176	367	543	388	380	768
GF	33FC	MA Grants	1,521	3,900	5,421	4,081	3,980	8,061
GF	13	HCA Admin - Contract	25	25	50	25	25	50
GF	REV1	FFP @ 32%	(8)	(8)	(16)	(8)	(8)	(16)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

Minnesota Statutes, section 256B.0625

Change Item Title: Streamlining Behavioral Health Regulation

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	1,859	920	3,068	3,271
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	1,859	920	3,068	3,271
FTEs	**2**	**2**	**25**	**24**

Recommendation:

The Governor recommends implementing the next phase of the Mental Health Uniform Service Standards (USS) project to reform the regulatory structure and service standards for mental health services in Minnesota. This next phase includes the transition of the regulation for several mental health service provider types, including Certified Community Behavioral Health Clinics (CCBHCs), from various processes in the Behavioral Health Division to one standard licensure process in the Licensing Division. This proposal will also update and streamline aspects of CCBHC regulation.

The Governor recommends investing $2.8 million in FY 2024-25 and $6.3 million in FY 2026-27 to transition these services to oversight by the Licensing Division, which will provide these programs with consistent oversight and legal due processes to ensure clients receive care for mental health issues safely.

Rationale/Background:

In 2021, the Governor proposed and the Legislature passed phase one of this work, creating a common set of standards for mental health services. This same session law also directed DHS to continue partnering with stakeholders to create a single comprehensive licensing structure for mental health service programs to improve the integration of mental health and substance use disorder services and to reduce the administrative burden on providers. Continuing to transition mental health services to one uniform oversight process will subtract provider administrative burdens and will ensure clients receive services under consistent requirements.

In 2021, the Minnesota Legislature passed a common core set of requirements that apply to many different types of mental health services paid for by the Minnesota Health Care Programs (MHCP). These requirements in Minnesota Statutes, chapter 245I, are known as the Uniform Service Standards (USS). Service providers and DHS worked collaboratively to develop these requirements to include more realistic timelines to complete treatment documents, standard staff training topics, simpler staff supervision processes, and a cohesive set of requirements. This process also incorporated feedback from culturally specific providers to address barriers to engaging clients in treatment. Although this was an important step, it was only the first phase in a process to align the department's oversight of many different service types.

Although several mental health services must follow the same core set of USS requirements there are two distinct DHS divisions that provide oversight of the services according to different processes, timelines, and additional requirements.

The Licensing Division provides oversight for:

- Intensive Residential Treatment Services (IRTS)/Residential Crisis Stabilization (RCS) facilities, and
- Mental health clinics.

The Behavioral Health Division provides oversight for:

- Certified Community Behavioral Health Clinics (CCBHC)
- Children's Therapeutic Services and Supports (CTSS)
- Adult Rehabilitative Mental Health Service (ARMHS)
- Mobile crisis
- Intensive treatment in foster care (ITFC)
- Intensive nonresidential rehabilitative mental health services (IRMHS)
- Assertive community treatment (ACT), and
- Community mental health centers (CMHC).

Service providers consistently voice concern with oversight by two different divisions as problematic, time consuming, confusing, and burdensome. These programs must navigate each of the different division's procedures and forms for applications, compliance reviews, and corrections for noncompliance with requirements. A review by the Licensing Division for some services may be followed by a Behavioral Health Division certification review only weeks later. Many of these services under different regulatory processes are provided by the same organization, the same staff persons, and at the same location. When DHS decides not to certify a provider or determines they are not meeting a standard, providers certified by the Behavioral Health Division lack any formal process or rights to appeal those determinations.

These challenges are particularly an issue for CCBHCs because they must provide several different types of licensed and certified services as part of their unique integrated model of care. Currently there are conflicting requirements amongst the different service types they provide. DHS reconciles the conflicts in requirements through a complicated variance process that allows providers to meet CCBHC standards instead of other requirements in statute, but this is not an ideal solution. CCBHCs proposed legislation in the 2022 session to require DHS to develop one consistent set of regulations to resolve these issues and has also asked DHS to propose a solution for the 2023 session. CCBHC providers have expressed a significant desire for the formal legal processes of reconsideration and appeals of DHS determinations that licensure provides and that are currently lacking under their current certification process.

Clients may also receive more than one type of mental health service at the same location. If a client or their family has a concern with services they receive or alleges maltreatment, they need to contact several different DHS divisions and county protection services to determine what part of DHS or a county agency might be responsible for investigating the maltreatment allegation or other concerns. If a staff person is determined to have abused a child or vulnerable adult, the response by DHS is very different as well. If the staff person responsible for abuse or maltreatment works in a licensed program, the provider must remove the person from any licensed program to ensure the safety of children and other clients. However, if the person works in a certified program there is not a similar statutory requirement to remove a person from providing services and the program would not even be made aware that one of their staff had been found responsible for maltreatment of a child or vulnerable adult.

Proposal:

Under this proposal, the following programs and services would be transitioned to licensure under the jurisdiction of the Licensing Division by January 1, 2026: CCBHC, CTSS, ARMHS, and mobile crisis. All providers of these additional services will transition at the same time, regardless of their association with a CCBHC, to ensure all people receive these services under the same set of protections and requirements.

To make this transition possible it is essential to collaborate with service providers, clients and their families, multiple DHS divisions, and other stakeholders to determine the changes in law necessary to complete this process. This collaborative process will identify the statutory changes necessary which will then be introduced in the 2025 legislative session. Even though the first phase of USS made many standards consistent across services there are still numerous inconsistencies that exist in the different service specific requirements and this phase will also align these wherever possible. When standards are clear and consistent, providers can spend more time delivering their full range of services and less time at their desks navigating confusing and ambiguous compliance requirements.

Although the oversight of these service standards would transition to the Licensing Division, the Behavioral Health Division will continue to perform the vital roles of determining the policy direction for many licensing standards and providing technical assistance to service providers. The Behavioral Health Division and Licensing Division will also maintain their continuous collaboration to improve the standards to ensure the requirements appropriately address the needs of the clients served in these programs. These two divisions already work in partnership to develop and refine licensing standards for many different types of behavioral health services that the Licensing Division already regulates.

When services are accountable under one unified licensing structure there is greater consistency in the regulation of standards, better integration of services for clients, centralized reporting and investigation of maltreatment and complaints, complete and ongoing checks of staff maltreatment and criminal histories, and access to enforcement tools necessary to protect Minnesotans. The department's intent is to move all certified services to licensure at some point. However, this proposal is only the second phase of a longer process and will focus on CCBHC providers that are under the most complex set of requirements. Because CCBHCs must provide a specific set of other certified services, this proposal would also transition these services at the same time.

Besides CCBHCs there are two other types of outpatient mental health centers and clinics with different sets of standards, Community Mental Health Centers (CMHC) and certified Mental Health Clinics. CCBHCs must also be concurrently certified as a Mental Health Clinic. Since the initial implementation of the CCBHC model in 2017, providers have voiced a need for a more streamlined set of regulations. Codifying CCBHC specific definitions and operational directives will minimize the complex web of requirements (federal and state) and reduce the administrative burden to providers and DHS. This transition process will also explore whether there is a need for these three distinct certifications with overlapping standards to determine if there is a way to consolidate the different types of clinics and centers and better align the requirements.

This proposal will also address ambiguity surrounding the scope of services, clinical and financial responsibility for CCBHCs providing services through formal contractual relationships via "Designated Collaborating Organizations" (DCOs) and allow CCBHC providers to complete a more streamlined report in lieu of a full cost report for the years between rate rebasing.

Impact on Children and Families:

This proposal will positively impact families and children. Background studies under chapter 245C for staff working in these programs will safeguard children by ensuring those providing services do not have a history of maltreatment or violent crimes. When a child or their family needs to report maltreatment or other concerns about a mental health services licensing requirements there will be one central place to report the allegations and DHS will thoroughly investigate the allegations according to a well-established process that reflects the unique responsibilities for programs. Service standards will be uniformly reviewed under a more consistent streamlined process that will allow service providers to spend less time interacting with numerous DHS staff from two divisions and more time providing their important mental health services.

Equity and Inclusion:

We anticipate that this proposal will increase equity in Minnesota's delivery of mental health services by clarifying for people the requirements for providing a specific service. There are a significant number of culturally specific programs providing ARMHS and CTSS services. Many of these programs are new to providing mental health services and clear regulations and oversight processes will assist in ensuring the success of culturally specific providers.

DHS Licensing has clear processes for issuing licenses, monitoring compliance with requirements, informing providers of noncompliance, and allowing providers reconsideration and appeal rights. This will benefit those providers by reducing the time between applying for a license and providing services to clients. Simplifying and clarifying the service evaluation process will allow providers to meet requirements while reducing their administrative burden. While this benefits all providers, it is particularly important for smaller and culturally grounded provider groups who often lack the more extensive compliance infrastructure of larger providers organizations.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

This proposal will impact tribes as providers. Several Minnesota tribes including the Fond du Lac Band of Lake Superior Chippewa, the Red Lake Nation, and the White Earth Nation directly perform mental health services, including CTSS, ARMHS, and outpatient therapy. As with other providers, tribes will benefit from clear and streamlined oversight over these operations. While there is some work necessary to come into compliance with any changed standards, the overall impact is expected to be a net reduction in the time and resources needed.

Tribal providers gave significant input for Phase One of this project, especially around barriers to accessing care that existed in the requirements for diagnostic assessments. DHS will consult with these tribal governments to ensure each tribe determines their course in this transition to licensure.

Impacts to Counties:

This proposal will have impact on counties as providers of services. Many Minnesota counties directly perform mental health services. This includes CCBHC clinics operated by some counties. As with other providers, counties will benefit from clear and streamlined oversight over these operations. While there is some work necessary to come into compliance with any changed standards, the overall impact is expected to be a net reduction in the time and resources needed.

IT Costs:
The Salesforce system will need to be updated to include license information for the certifications transitioning to licensure along with the other types of certifications and licenses these organizations currently hold.

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll						
Professional/Technical Contracts	4,185,000	185,000	185,000	185,000	185,000	185,000
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)	1,526,131	1,632,746	1,698,937	1,614,897	1,614,897	1,614,897
Total	**5,711,131**	**1,817,746**	**1,883,937**	**1,799,897**	**1,799,897**	**1,799,897**
MNIT FTEs	6	6	6	6	6	6
Agency FTEs	2	2	2	1	1	1

Results:
People receiving these services and their families will benefit by knowing all staff providing services have passed a background study and if they do have concerns with any services, they can reach out to one contact point at DHS to report maltreatment of a child or a violation of licensing standards.

Clients will experience greater integration of care by receiving services under one assessment and treatment planning process according to the same requirements.

Providers will experience a decrease in the number of reviews that take place on an ongoing basis. Currently many of these programs provide multiple different services and experience four different reviews by the Behavioral Health Division and several additional reviews by the Licensing Division depending on the number of licenses and certifications they hold. This proposal will simplify this process to a review by only one division for all services transitioning and will decrease to as few reviews as possible. The Licensing Division will collaborate with providers to create a process and license structure that reduces the number of reviews as much as possible while not overburdening providers with a review of too many services at once.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 27-28
General Fund			1,859	920	2,779	3,068	3,271	6,339
HCAF								
Federal TANF								
Other Fund								
Total All Funds			1,859	920	2,779	3,068	3,271	6,339
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	OIG Licensing FTEs (Licensing, Intake and Investigations, Support, and Supervision) (0,0,19,19)	0	0	0	2,581	2,879	5,460
GF	11	OIG Legal Counsel FTEs (Attorneys) (0,0,2,2)	0	0	0	209	347	556
GF	11	OIG Background Studies FTEs (Researchers) (0,0,2,2)	0	0	0	321	286	607
GF	11	OIG Product Team (Product Owner and MH/SUD/CRF Stakeholder Engagement (2,2,2,1)	274	318	592	318	165	483
GF	11	MNIT Enterprise Services FTEs (6,6,6,6)	626	657	1,283	690	725	1,415
GF	11	Annual Software Licensing Costs (Salesforce, S-Docs, Smarty Streets, DocuSign)	34	34	68	33	33	66
GF	11	Implementation Costs	1,000	0	1,000	0	0	0
GF	11	Azure Data Lake	13	13	26	13	13	26
GF	REV1	DHS Admin FFP @ 32%	(88)	(102)	(190)	(1,097)	(1,177)	(2,274)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
			2	2		25	24	

Change Item Title: Drug Formulary Committee (DFC) Modifications

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	(20,202)	(39,336)	(39,289)	(39,353)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	(20,202)	(39,336)	(39,289)	(39,353)
FTEs	**0**	**0**	**0**	**0**

Recommendation:
The Governor recommends eliminating the sunset of the Drug Formulary Committee (DFC) and expanding the representation of consumers and providers on the committee. This proposal produces a savings of $59,538,000 in the FY2024-2025 biennium and $78,642,000 in the FY2026-2027 biennium.

Rationale/Background:
The Drug Formulary Committee (DFC) is a committee of licensed and actively practicing health care providers who volunteer to evaluate the safe and effective use of prescription drugs in Minnesota's public health care programs (Medicaid and MinnesotaCare). The DFC is established in state statute (see Minnesota Statutes 256B.0625, subd. 13c).

The DFC is responsible for managing the MHCP Preferred Drug List (PDL), and allows for community healthcare providers to evaluate whether drugs covered by public programs should be subject to prior authorization, what the prior authorization criteria should be, and allows for the public to provide feedback and comments on the DFC's activities by conducting all business during public meetings where public comment is allowed and encouraged.

Without the DFC, the department would be unable to establish prior authorization criteria to address high-cost drugs and issues of safety and efficacy. The inability of DHS to manage the PDL as a result of the expiration of the DFC would result in the loss of hundreds of millions of dollars in rebates to the state each fiscal year, and would result in a loss of the public's ability to participate in the management of the pharmacy benefit.

During the 2021 legislative session, the Department of Human Services (DHS) was directed to produce a report that detailed the current composition and activities of the DFC. Through the public engagement process, there was a clear desire from those that participated to have more representation on the committee by current, or former, MA members. There was also a desire for additional provider representation to allow for diverse backgrounds and expertise.

The DFC is currently scheduled to sunset on June 30, 2023. If the DFC were to sunset, not only would public participation be impacted, but DHS would not be able to operationalize the preferred drug list which would result in tens of millions of dollars in rebates being lost annually.

Proposal:

This proposal will expand the membership of the Drug Formulary Committee to add an additional consumer representative seat to be held by a current or former Minnesota Health Care Program enrollee and add flexibility to add up to two additional seats as needed for healthcare provider representation, effective in FY24. This proposal also eliminates the sunset of the DFC, which is currently set for June 30, 2023, to ensure future PDL management with public input.

Under current law, the DFC will sunset on June 30, 2023, and as the management of the Preferred Drug List (PDL) is the primary responsibility of the DFC, its expiration will result in the loss of supplemental pharmacy rebates due to the inability of DHS to manage the PDL and prefer certain drugs over others in the same class. While the PDL governs the drug benefit for both Medical Assistance and MinnesotaCare, only a forecast impact to MA is estimated, as MinnesotaCare is not eligible for drug rebates.

Forecast savings are partially offset by funding for three additional representatives on the DFC for a total of 16 members, with an average per diem plus mileage rate of $150 per meeting, and four meetings per year. Federal Financial Participation is estimated at 32%.

This proposal also allows for the continuation of legislatively mandated report for the cost of dispensing survey that is conducted every 3 years by DHS. Legislation passed in 2021 modified the end date of certain legislative reports, changing the cost of dispensing report to be sunset as of January 1, 2024. This survey will continue absent the legislative report requirement; DHS believes the transparency of this legislative report is important to continued collaboration with pharmacy stakeholders.

Impact on Children and Families:

This proposal would continue to ensure that all members of the public, including children, youth, families, advocacy organizations, and other interested parties, get an opportunity to participate in the administration of the pharmacy benefit for our public health care programs, and that the state is able to continue to negotiate drug rebates. This proposal would help ensure children and families continue to have access to the pharmacy benefit in public programs by administering the benefit in a safe, effective, and cost-efficient manner. Because pharmacy services are an optional benefit, it is crucial to administer the benefit efficiently to ensure it continues to be available for enrollees in our programs. Most diseases are now treated with prescription drugs. By ensuring the pharmacy benefit is administered properly, Minnesotans will live healthier lives and minimize the disease burden on future generations. This proposal is at its core a mechanism for engaging children and families. This proposal will ensure that children and families will be able to be engaged in the administration of the pharmacy benefit in public programs into the future and without a risk of their engagement sunsetting.

Equity and Inclusion:

This proposal ensures that enrollees receiving health care coverage through public programs have a mechanism to engage with the department in the administration of the pharmacy benefit. This proposal reduces inequities by preserving this engagement into the future, rather than sunsetting the engagement in two years. It also provides an opportunity for enrollees in MA to have a seat at the table in this process. The proposal preserves a mechanism for all Minnesotans to have a voice in the administration of the pharmacy benefit for public programs.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
This proposal does not impact counties.

IT Costs
This proposal does not have any IT components.

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of DFC meetings that are held after the sunset date	N/A	Sept. 2022	0	Avg. 4 per year	Annual
Quality	Number of stakeholders providing public comment at DFC meetings	10-15	Sept 2022	10-15	20	Average per meeting, annual
Results	Number of new seats added to the DFC	N/A	Sept. 2022	0	1+	CY2023

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
General Fund			(20,202)	(39,336)	(59,538)	(39,289)	(39,353)	(78,642)
HCAF								
Federal TANF								
Other Fund								
Total All Funds			(20,202)	(39,336)	(59,538)	(39,289)	(39,353)	(78,642)
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	33	MA Grants	(20,209)	(39,343)	(59,552)	(39,296)	(39,360)	(78,656)
GF	13	HCA Admin - per diems	10	10	20	10	10	20
GF	REV1	FFP @ 32%	(3)	(3)	(6)	(3)	(3)	(6)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):
Minnesota Statutes, section 256B.0625, subd. 13c
Minnesota Statutes, section 256B.0625, subd. 13e, paragraph (h)

Change Item Title: Supporting Health Care Coverage and Transitions in Care for Urban Indians

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	2,522	2,526	2,526	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	2,522	2,526	2,526	0
FTEs	**0.25**	**0.25**	**0.25**	**0**

Recommendation:

The Governor recommends $5,048,000 in FY2024-2025 and $2,526,000 in FY2026-2027 for the Indian Health Board (IHB) of Minneapolis to support continued access to health care coverage through Minnesota Health Care Programs, improve access to quality care, and increase COVID-19 vaccination rates among urban American Indians. This proposal recognizes the unique care opportunities provided by IHB and passes along additional funds that the state is receiving for services they provide.

Rationale/Background:

American Indians living in Minnesota experience high rates of uninsurance[1], significant health disparities, and social drivers of health, such as homelessness and poverty, when compared to other populations. Infant mortality rates of American Indians, along with African Americans, are higher than those of other Minnesotans. Mortality rates from chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault, homicide, intentional self-harm/suicide, and chronic lower respiratory diseases are also higher among American Indians as compared to the total population.

The COVID-19 pandemic disproportionately impacted American Indian communities, including those who reside in urban areas. The pandemic response also highlighted the importance of maintaining health care coverage to ensure that people can access the care they need when they need it. Moreover, many Minnesotans have experienced disruptions in care necessary to manage chronic illnesses and delayed preventive care and screenings. This is particularly true for low-income Minnesotans who already had barriers to accessing care.

American Indians in Minnesota overall also have lower COVID-19 vaccination rates than other racial and ethnic groups across the state. American Indian tribes in Minnesota were able to vaccinate high numbers of American Indians who reside on or around reservation lands, but vaccination rates for urban Indians remain significantly lower, resulting in higher risk of contracting COVID-19 and experiencing adverse effects.

[1] According to the 2021 Minnesota Health Access Survey, while the overall uninsurance rate for Minnesotans was 4.0% in 2021, the uninsurance rate for people of color and American Indians was 10.2%. (https://www.health.state.mn.us/data/economics/hasurvey/docs/mnha2021infographic.pdf)

The IHB is one of the 35 Urban Indian Health Programs in the country, operating under Title V of the Indian Health Care Improvement Act, PL 94-437. As an Urban Indian Health Program, the IHB contracts with the Indian Health Services to receive grant funding for serving the needs of American Indians who live in the Twin Cities, an urban area of Minnesota. The IHB provides medical and dental care and counseling services to approximately 5,000 people in the Twin Cities area, many of whom are uninsured and American Indian. The IHB also serves as one of the ten Federally Qualified Health Centers (FQHCs) participating in the FQHC Urban Health Network (FUHN), which operates as an accountable care organization (ACO) within Minnesota's Integrated Health Partnership (IHP) program. Approximately 80 percent of people served by the IHB are residents of Minneapolis, with an additional 12 percent living in St. Paul.

Under the provisions of the American Rescue Plan Act (ARPA) of 2021, the federal government provided a 100% federal match for services provided to Medicaid beneficiaries who receive care through Urban Indian Organizations for two years, through March of 2023. Although the state receives the additional funds, there is no federal requirement that states direct additional funds to these organizations, and current state law does not allocate these funds to DHS or permit DHS to pass along additional funding to IHB.

Proposal:

This proposal would provide a total of $7.5 million in grant funding to the IHB to expand efforts aimed at keeping eligible urban American Indians enrolled in Medicaid, improving access to quality health care, and to increase COVID-19 vaccination rates. Additional resources for these activities are particularly crucial as unwinding from continuous coverage provisions that were in place during the federal Public Health Emergency (PHE). This proposal also recognizes that the state will receive increased federal funding for care for this community, and invests additional dollars into reducing health disparities experienced by urban Indians and ensuring they continue to have access to needed health care.

Examples of activities that would be allowable uses of this funding include Medical Assistance application assistance, increased care coordination, and outreach/navigation by community health workers to address health care needs and other social drivers of health. In addition, funds would be used to support COVID-19 vaccine initiatives aimed at increasing the rate of urban American Indians that are vaccinated. Activities include patient and community outreach, community vaccination events, or other activities to promote vaccine acceptance and uptake within the urban Indian community.

DHS would require 0.25 FTE in the Purchase and Service Delivery division of the Health Care Administration to administer the grant.

Impact on Children and Families:

Urban American Indian families and children would benefit from these additional resources.

Equity and Inclusion:

This proposal advances equitable access to quality health care for urban American Indians, who are disproportionately impacted by COVID-19, are impacted significantly by social drivers of health, and experience higher rates of health disparities compared to other Minnesotans. The services funded through this proposal are delivered by trusted providers in culturally respectful and appropriate ways.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

This proposal would not directly impact services provided by or payments made to tribes, but would impact those tribal members who live inside the Twin Cities metropolitan area. Coordination between tribes and the IHB would be important to ensure access to the most appropriate and impactful services available.

Impacts to Counties:
This proposal does not directly impact counties.

IT Costs
This proposal does not have an IT component.

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of urban American Indians served through activities eligible for grant funding. Number of urban American Indians who have MA coverage. Number of vaccinations provided to urban Indians.					
Results	Increased vaccination rates for American Indians enrolled in Minnesota Health Care Programs					

Evidence-based Practice	Source of Evidence
Health insurance enrollment outreach & support	Health insurance enrollment outreach and support programs assist individuals whose employers do not offer affordable coverage, who are self-employed, or unemployed with health insurance needs; individuals may be uninsured or need assistance renewing coverage. (Source: What Works for Health, https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/health-insurance-enrollment-outreach-support)

Fiscal Detail:

Net Impact by Fund (dollars in thousands)	FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund	2,522	2,526	5,048	2,526	0	2,526
HCAF			0			0
Federal TANF			0			0
Other Fund			0			0
Total All Funds	2,522	2,526	5,048	2,526	0	2,526

Fund	BACT#	Description	FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
GF	51	HCA Admin - Grant to IHB	2,500	2,500	5,000	2,500		2,500
GF	13	HCA Admin - FTEs (0.25, 0.25, 0.25, 0)	33	38	71	38		38
GF	REV1	FFP @ 32%	(11)	(12)	(23)	(12)		(12)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	13	HCA Admin - FTEs (0.25, 0.25, 0.25, 0)	0.25	0.25		0.25		

Statutory Change(s):

N/A

Change Item Title: Preserving Funding for Medical Education and Research Costs

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	15,158	18,382	18,366	18,192
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	15,158	18,382	18,366	18,192
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends transitioning funding for the Medical Education Research Committee (MERC) grants from the managed care Medical Assistance rates to the Medical Assistance fee-for-service rates in order to comply with federal requirements while preserving MERC payments to providers. This proposal requires an investment of $33,540,000 in the FY2024-2025 biennium and $36,558,000 in the FY2026-2027 biennium.

Rationale/Background:

The training of new physicians and allied health professionals is vital to the stability of Minnesota's health care infrastructure and the health of all Minnesotans. The Medicare program sets payment rates for hospitals in a way that explicitly recognizes Medicare's share of the costs of training new medical professionals. Since Minnesota's establishment of MERC in 1996, the Centers for Medicare and Medicaid Services (CMS) has also allowed Minnesota to recognize medical training costs in the payment rates for Medicaid services.

Minnesota has historically included payment for medical training in Medical Assistance managed care rates in order to secure federal matching funds and has transferred those funds to the Department of Health to distribute payments to the teaching sites via the MERC grant program. The method Minnesota used to incorporate the medical training costs into the managed care rates and make payments to training sites was different from methods used by other states, and required the submission and approval of an 1115 Medicaid waiver.

In 2016, CMS released a final rule that indicated that payments like MERC that are made through managed care capitation rates are no longer permissible; since then, Minnesota has received additional guidance that CMS will no longer approve the provisions of Minnesota's waiver. In order to continue to recognize medical education costs in the Medicaid rates in Minnesota, the funding and the distribution of the payments needs to be reconfigured within the managed care rates or shifted to the fee-for-service rates.

In conversations with CMS since that time, it has become clear that DHS will not be granted an extension for the waiver that allows MERC payments to continue as currently structured. Because of this, the November 2022 state forecast assumes that authority for this waiver ends effective January 1, 2023.

Proposal:

This proposal would reinstate MERC payments in the forecast, and instead of incorporating medical education costs in the managed care rates, shifts them to fee-for-service rates. This will allow DHS to comply with the 2016 Managed Care rule, and will provide the best opportunity to preserve the MERC program in a manner that approximates its current structure. Time will be needed to incorporate the MERC funding into the fee-for-service rates. In order to maintain the current funding cadence, this proposal would also implement one-time supplemental payments totaling $49.5 million to training hospitals in calendar year 2023. This proposal would also result in the least amount of disruption to medical education training sites who currently benefit from the program.

The proposal would amend several sections of statute to repeal the current methodology for including MERC funding in the managed care rates and the distribution of funding to training sites via the MERC grant program. These changes are needed for federal compliance. The proposal will also repeal a transfer from the University of Minnesota to the Department of Human Services, as well as the associated grants to the U of M Medical School, in compliance with federal guidance. Changes may also be made to the MERC funding distribution formula.

Because of the new fee-for-service methodology, the state will be able to pull down more federal funds per dollar than in the construction in current state law; this proposal assumes that the total dollar amount in statute for MERC payments outside of those described in the previous paragraphs (a total of $49,552,000 per fiscal year) will continue, but that state share will be decreased from the managed care rate methodology. A cost to the forecast is still estimated due to the assumption that federal authority for the MERC program will expire at the end of calendar year 2022 without further action from the state.

Impact on Children and Families:

All Minnesotans are best served when educators and providers can continue to work together to maintain a robust training infrastructure that will produce a steady supply of new and competent medical professionals.

Equity and Inclusion:

All Minnesotans are best served when educators and providers can continue to work together to maintain a robust training infrastructure that will produce a steady supply of new and competent medical professionals?

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:

This proposal has no specific or direct impacts on counties.

IT Costs

This proposal will require programming to implement the medical education factor in the FFS inpatient hospital payment rates.

Results:

Part A: Performance measures

This proposal will enable Minnesota to continue to receive Medicaid funding for recognizing the costs of medical education in our Medicaid payments to hospitals.

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Level of medical education funding in Medicaid rates	$49.5 million	2023	$0	$49.5 million	2024
Quality						
Results						

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
General Fund			15,158	18,382	33,540	18,366	18,192	36,558
HCAF								
Federal TANF								
Other Fund								
Total All Funds			15,158	18,382	33,540	18,366	18,192	36,558
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	33ED	MA Grants	5,507	6,610	12,117	6,186	6,124	12,310
GF	33AD	MA Grants	1,287	1,469	2,756	1,473	1,518	2,991
GF	33FC	MA Grants	8,364	10,303	18,667	10,707	10,550	21,257
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

- Section 62J.692 multiple subdivisions – this section describes the distribution of the MERC funds (subd. 4) and authorizes the transfer of funds from DHS to MDH (subd. 7). Other subdivisions will likely also need to be amended.
- Section 137.38 through 137.40. These are the grants that return funds to the U of M.
- Section 256B.69 subd 5c – describes the carve-out of the MERC funding from the MCO payments.
- 256B.75(b) describes the FFS rates for outpatient services in Critical Access Hospitals. These will need to be amended to include a provision to increase CAH outpatient rates to include a MERC factor.
- 256.969 subd 2b describes the current FFS inpatient hospital rates. This section will need to be amended to include a DHS determined facility specific medical education rate factor.

Change Item Title: Innovations in Health Care Purchasing

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	506	2,188	1,690	1,690
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	506	2,188	1,690	1,690
FTEs	**4**	**4**	**4**	**4**

Recommendation:

This recommendation furthers the development of innovative total cost of care payment models that integrate social services and health care service delivery for Medicaid beneficiaries. This recommendation invests $2.7 million in FY 2024-25 and $3.4 million in FY 2026-27 to support counties, tribes, DHS staff, and collaborating provider organizations, in:

1) Identifying and designing additional approaches for ensuring effective and efficient payment that improve the health and well-being of vulnerable populations in Minnesota. This includes building on lessons learned from existing value-based payment models both locally and nationally, and seeking changes as needed in state or federal authority.
2) Creating a demonstration or pilot opportunity for entities to test next steps toward aligning financial incentives that integrate social and health care costs and outcomes and that can include unique needs of persons with disabilities, or other populations and providers not yet included in other Medicaid alternative payment models. The demonstration would include grant support to strengthen organizational capacity and infrastructure readiness for collaboration across a broader spectrum of community partners.

Rationale/Background:

Current accountable care models have successfully created opportunities for integrated health systems and primary care systems at paying for outcomes. However, these models have been limited to non-dually eligible Medicaid beneficiaries and to incorporation of costs that are more directly associated with health care services. The unique challenges of serving Medicaid beneficiaries in rural Minnesota has also highlighted the need for additional flexibilities that cut across the continuum of health care and social services, and include dual eligible beneficiaries. Interest from additional providers and other organizations to participate in payment models that reward outcomes and quality of care instead of increased utilization has remained strong, but additional supports are required to design and implement options for these entities. With increased workforce challenges, it is more critical than ever that county, health care, and social service provider's financial incentives are aligned to support innovative and efficient ways to meet needs of vulnerable populations. This includes more formally and systematically recognizing the costs and savings in the health and social service system from care and services that extend beyond paid provider supports.

In a phased approach, DHS would initiate planning and gather input through Request for Information (RFI), and other community engagement forums to identify model options. These efforts would lead to design and proposal of a demonstration that would support greater participation of home and community-based providers and other partners in the continuum of care. It enables the more systematic collection and analysis of costs across health and social service sectors.

Proposal:

This is a new initiative that builds on previous efforts (i.e., Integrated Health Partnerships, study of value-based payment options for Home and Community Based Service waivered service providers) and takes next steps for work not currently funded.

The proposal will buy administrative capacity to support the planning and implementation phase, including a contract for project management and four FTEs in the Health Care and Aging and Disability Services Administrations, as well as grant support for organizations selected for the pilot demonstration that total $2 million per fiscal year.

In FY 2024, external project consultation will lead the planning, lend additional project management capacity and provide additional perspective on options and considerations. In FY 2024-27, it is estimated that 6.5 FTEs will be needed to prepare and implement the demonstration. This estimate is based on staffing levels required to support implementation of current value-based payment model. Staff swill support engagement with state and federal partners to gather feedback on options, research options and design of long-term services and supports (LTSS) quality measures, and incentive payment structure, and assist in analyzing and coordinating with existing programs, contracts and services. Staff would also administer and support evaluation of results from the demonstration.

$2.0 million in grant dollars in FY 2024, $1.5 million in FY 2025, and $1.3 million each in FY 2026-27 would be made available to demonstration participants. The size and number of grantees would be determined based on input gathered through the initial planning year. Demonstration grants would support organizational capacity for participants, and infrastructure investments needed to capture, exchange and use information among partners to coordinate care and report outcomes.

Results of the demonstration would inform impacts and overlaps on payments and other programs in the future. It is anticipated that these alternative models will result in long-term cost effectiveness for service delivery. However, it will take time for demonstration participants to establish processes, and up to a year before potential impacts, overlaps and anticipated future costs or savings will be determined.

Current alternative payment models require that investments by participating organizations be made back through expected savings, and as a result do not always sufficiently incentivize bringing to scale larger changes and upfront costs associated with care delivery and payment reform. By offering a grant supported option through the pilot phase, organizations can bring innovations to scale or take next implementation steps with less risk. This proposal addresses a gap for providers, community organizations, and county services who desire to participate in alternative payment models but have needed the financial, data, and other resources to take broader steps in forming necessary connections.

Impact on Children and Families:

Integrating social service supports into medical care helps improve outcomes and lowers cost of care for everyone. Families in most need of supports that span both health and social service providers would benefit from this proposal because it strengthens the financial alignment and coordination between partners working to improve health and quality outcomes.

Equity and Inclusion:

Current Medicaid options for participating in alternative payment models have been limited to providers serving non-dually eligible beneficiaries. This proposal addresses this inequity by identifying payment models that can better support people with disabilities.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
Counties will be engaged as part of the planning process and could be participants in voluntary demonstration arrangements. Alternative model options are expected to include strengthening connections between providers, counties and community partners. Demonstrations may result in long-term savings to some counties, but participants may have initial costs supported through grant funds.

IT Costs
No IT costs are anticipated for this proposal.

Results:
The administrative and support resources included in this proposal will result in identification and development of measures to apply to the payment models, as well as the necessary support to participating organizations around the collection of additional data to improve measurement, and to calculate baselines and goals with stakeholders and beneficiaries. Important domains will include service delivery and effectives, person-centered planning and coordination, and person choice and satisfaction with services and supports.

Supporting Evidence-based practices:

- Making Alternative Payment Models Work For Patients | Health Affairs
- More that unites us than divides us? A qualitative study of integration of community health and social care services | BMC Primary Care | Full Text (biomedcentral.com)
- Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs | IHI - Institute for Healthcare Improvement

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			506	2,188	2,694	1,690	1,690	3,380
HCAF								
Federal TANF								
Other Fund								
		Total All Funds	506	2,188	2,694	1,690	1,690	3,380
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	51	Health Care Grants	0	1,486	1,486	1,260	1,260	2,520
GF	13	HCA Admin - Contracts	200	400	600			0
GF	13	HCA Admin - FTEs (2, 2, 2, 2)	280	326	606	326	326	652
GF	14	ADSA Admin - FTEs (2, 2, 2, 2)	264	306	570	306	306	612
GF	REV1	FFP @ 32%	(238)	(330)	(569)	(202)	(202)	(404)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	13	HCA Admin - FTEs (2, 2, 2, 2)	2	2		2	2	
GF	14	ADSA Admin - FTEs (2, 2, 2, 2)	2	2		2	2	

Change Item Title: Modifying the Withhold Measures for Managed Care Contracts

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
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**

Recommendation:
The Governor recommends modifying the statutorily required withhold measures used in the Medical Assistance (MA) families and children and MinnesotaCare managed care contracts. This proposal is budget neutral and any future costs are indeterminable.

Rationale/Background:
Managed care withholds are an important tool in ensuring managed care organizations (MCOs) are focused on quality of care for enrollees. The current withhold for Emergency Room Utilization, Hospital Admission and Hospital Readmission are set forth in Minnesota Statutes, section 256B.69, subdivision 5a, and have been in place for several years.

For over a decade, DHS has been working with the MCOs to report and share withhold measure data and results and adopting targets as standard measures evolve, or the area in most need of improvement requires greater focus, especially in the area of reducing disparities. The MCOs have improved the rates on all measures and have achieved the target on the ED measure, or are at a stable and relatively high performing rate such that target is not able to motivate further improvement. DHS will continue to monitor, calculate and report quality withhold results in collaboration with MCOs. This can be a more robust and effective activity by removing the separate and outdated Emergency Department Utilization, Hospital Admissions and Readmission targets, allowing the utility of the measures to be regularly evaluated and updated as needed.

Proposal:
This proposal amends state law to modify the withhold measures outlined in statute to give DHS more flexibility in addressing health outcomes. Retiring these sections where specific targets are named allows DHS to ensure quality targets are meaningful and consistent with the statutory direction for the use of withholds.

Withhold measures currently being considered by the agency are likely to be met by all current MCOs who provide health care coverage to MA and MinnesotaCare enrollees. The impact of future measures that may not be met by all MCOs is indeterminable.

Impact on Children and Families:
Managed care withholds are an important tool in ensuring MCOs are focused on quality of care for enrollees. Access to emergency care and hospital care are essential and costly services. Quality targets based only on utilization reduction may result in greater hardship for some enrollees to engage with their health care providers.

Efforts to support and encourage enrollees in seeking and obtaining the right level of care at the right time is multi-faceted and should be addressed through a variety of quality incentives.

Equity and Inclusion:

ED and hospital utilization rates vary by population, including racial and ethnic groups, age groups and region. Current targets do not account for nor support transparency in how the ED utilization, hospital admissions, and readmissions for different groups within the MA and MNCare enrollment may differ. Data may indicate disproportional utilization by certain groups of enrollees which could then lead DHS and the MCOs to take quality improvement actions, or better understand and address access to care issues.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:

This proposal does not impact counties.

IT Costs

No IT impacts are estimated as a part of this proposal.

Results:

Use of a variety of quality measures in MCO withholds is an existing program. Results for these measures are published as part of the annual quality report. Per the parameters in the section 256B.69, subdivision 5a, paragraph (c), the number of quality measures that are part of the withholds has varied over time but always includes these three: Emergency Room Utilization, Hospital Admission and Hospital Readmission.

MCOs have made incremental improvement in decreasing ED utilization and stabilizing hospital admission and readmission rates. Additionally, MCOs have improved the rated on all measures and have achieved the target on the ED measure.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund								
HCAF								
Federal TANF								
Other Fund								
Total All Funds								
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

Minnesota Statutes, section 256B.69, subd. 5a

Change Item Title: Value-Based Arrangements for Drug Purchasing

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	253	276	276	276
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	253	276	276	276
FTEs	**1**	**1**	**1**	**1**

Recommendation:

The Governor recommends $253 thousand in FY 2024 and $276 thousand each year thereafter to modify state law to allow the Department of Human Services (DHS) to enter into value-based purchasing arrangements with drug manufacturers to obtain supplemental drug rebates outside of the Preferred Drug List (PDL) to lower health care spending for prescription drugs in public programs.

Rationale/Background:

Currently, DHS is restricted in only claiming supplemental drug rebates through the Preferred Drug List (PDL). Members of the Drug Formulary Committee (DFC) make recommendations on drug "preferences" to favor drugs with high efficacy and low cost, through waiving prior authorization requirements, requiring a lower co-pay, or other utilization management techniques. Given statutory authority, Minnesota is only able to claim rebates from drug manufacturers on those drugs that are on the PDL.

The Centers for Medicare and Medicaid Services (CMS), and the drug purchasing industry as a whole, has begun to allow for the collection of drug rebates through value-based purchasing arrangements. These arrangements allow for a greater rebate when the drugs don't work, or don't work as well as expected, and smaller discounts when the drugs work well. Differential rebate amounts can help drug purchasers, including states, to right-size payments for prescription drugs and avoid over-payment for drugs with low effectiveness. By allowing drug rebates outside of the PDL, the State of Minnesota would be able to lower drug costs further and continue to incent use of drugs that are most effective and contribute to better health outcomes for enrollees.

DHS requires legislative authority to enter into value-based agreements, which are allowed and supported by CMS.

Proposal:

This proposal will give DHS statutory authority to negotiate and enter value-based arrangements with drug manufacturers for supplemental drug rebates outside of the Preferred Drug List (PDL).

Because DHS does not have available data to determine the number or composition of drug manufacturers who would show interest in participating in value-based arrangements, the drugs that would be covered through such arrangements, or the amount of rebates associated with any agreements into which the state enters, DHS is not able to quantify a forecast impact as a result of this proposal.

This proposal includes funding for one pharmacist to evaluate proposals from drug manufacturers, and to monitor data collection and execute agreements. This proposal also includes funding for a contract amendment with the state's PDL management company to allow them to negotiate with drug manufacturers on behalf of the state.

Equity and Inclusion:

This proposal does not alter any covered services or benefit delivery and would therefore not be expected to have a measurable impact on equity or inclusion. The services that these agreements would apply to are already covered services. This proposal simply allows DHS the ability to lower healthcare costs through the use of valued based purchasing agreements.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:

This proposal does not directly impact counties.

IT Costs

No systems costs are anticipated as a result of this proposal.

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Amount of discounts received under these arrangements	N/A	Sept. 2022	$0	TBD	Annual
Quality	Number of claims for drugs that generated VBP payments due to the drug's underperformance	N/A	Sept. 2022	0	TBD	Annual
Results	Aggregate costs for drugs covered under VBP arrangements before and after the VBP arrangements are executed	N/A	Sept. 2022	$0	TBD	Annual

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			253	276	529	276	276	552
HCAF								
Federal TANF								
Other Fund								
Total All Funds			253	276	529	276	276	552
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	13	HCA Admin - FTEs (1,1,1,1)	172	206	378	206	206	412
GF	13	HCA Admin - Contract	200	200	400	200	200	400
GF	REV1	FFP@32%	(119)	(130)	(249)	(130)	(130)	(260)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	13	HCA Admin - FTEs (1,1,1,1)	1	1		1	1	

Statutory Change(s):

Minnesota Statutes, section 256B.0625

Change Item Title: Modify Inpatient Hospital Data Inputs due to COVID-19

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
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**

Recommendations:
The Governor recommends codifying the best next data set to be used for prospective payment system (PPS) hospital rebasing in order to account for years impacted by COVID-19, to ensure that hospital rates are not adversely impacted by decreased utilization during 2020. This proposal is budget neutral.

Rationale/Background:
The COVID-19 pandemic forced hospitals to shut down elective surgeries for several months in early 2020. In addition, many people put off other types of hospital care prior to the availability of the COVID vaccine due to fears of contagion. This resulted in claims data from 2020 not being representative of a typical operating year. (Claims volume for 2021 may also have been affected by pandemic impacts, but to a lesser extent than 2020 claims.)

In 2021, the legislature implemented a change to Minnesota Statutes, section 256.969, subd. 2b, paragraph (h), directing the Department of Human Services (DHS) not to use claims data from years in which volume was significantly altered due to a pandemic. For the upcoming Rebase 5, which is effective July 1, 2023, calendar year 2020 would have been included in the base year. DHS will need to begin working on the next rebasing methodology later this year and to date, an alternative base year for Rebase 5 has not been codified.

Proposal:
This proposal would codify the appropriate base year in order to use the most representative data possible for setting future inpatient hospital rates. DHS is working with stakeholders to determine the best option for the needed base year data. The proposal is in line with current forecast projections, which assume that rebasing adjustments will occur based on an inflationary factor that does not contemplate 2020 claims.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
This proposal does not impact counties.

IT Costs

This proposal does not have IT costs.

Results:

The efficacy of this proposal will be measured by the feedback we get from the hospital providers. A fair proposal will garner support from hospitals. DHS aims to set rates that are adequate to maintain access to services for the enrollees in Minnesota Health Care Programs. Currently, all but two Minnesota hospitals participate in our programs. This is somewhat unique among state Medicaid programs and is a testament to the level of commitment our hospitals have to the citizens of our state.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund								
HCAF								
Federal TANF								
Other Fund								
Total All Funds								
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

Minnesota Statutes, section 256.969

Change Item Title: Establishing Medicaid Sanctionable Behavior Standards for Unsafe Opioid Prescribing Practices

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	136	136	136	136
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	136	136	136	136
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends codifying standards developed by the Opioid Prescribing Work Group that define sanctionable behavior for providers enrolled in the Medicaid and MinnesotaCare programs. Sanctionable behavior includes persistent unsafe prescribing practices or prescribing practices that are inconsistent with community standards, in alignment with the recommendations of the Opioid Prescribing Work Group. This proposal also seeks funding for clinical support of the quality improvement efforts. The total cost of this proposal is $136 thousand per year.

Rationale/Background:

The 2015 the Minnesota Legislature passed the Opioid Prescribing Improvement Program (OPIP) to reduce opioid dependency and substance use in the state by establishing best practices, standards, and implementing quality improvement activities related to opioid prescriptions (Minn. Stat. § 256B.0638). This program covers all providers who are enrolled with the Minnesota Health Care Programs (MHCP).

A core component of OPIP is the Opioid Prescribing Work Group (OPWG). The OPWG met 48 times between 2015 and 2021 to meet its charge of gathering community and expert input and develop recommendations on the following five statutorily mandated activities.

- Develop protocols to address all phases of the opioid prescribing cycle (acute, post-acute and chronic pain);
- Develop sentinel measures centered on evidence-based practices;
- Oversee development of educational resources and messages for providers to use in communicating with patients about pain and the use of opioids to treat pain;
- Recommend quality-improvement measures to assess variation and support improvement in clinical practice; and
- Recommend two sets of thresholds directed at MHCP-enrolled providers with persistently concerning prescribing practices, one threshold that will trigger mandatory quality improvement and the other termination from MHCP.

In 2021, the OPWG finalized and voted to approve the standards that would inform when providers could be sanctioned for opioid prescribing practices.

While the current statutory language directed the OPWG to define thresholds that would trigger disenrollment, through extensive discussion the OPWG recommended a broader approach than simply establishing standards for

disenrollment from MHCP. This revised approach of defined sanctionable behaviors is responsive to changes in the prescribing landscape throughout the state since 2015 when the legislative directive was drafted. Additionally, the OPWG wanted to leverage more than the blunt tool of disenrollment and provide the DHS Office of Inspector General (OIG) with more tools to address unsafe prescribing practices. Under the revised approach OIG can use a variety of approaches to sanction providers in order to incentivize changes in prescribing practices.

Proposal:

This proposal codifies recommendations from the OPWG to establish a definition of sanctionable behavior for providers in MHCP with persistent unsafe prescribing practices or prescribing practices are inconsistent with community standards. The standards recommended by the OPWG are as follows:

Continuing COAT at the same dose when risk factors for serious opioid-induced respiratory depression are present: Community standards require that a patient-centered safety plan must be established if a prescriber is continuing chronic opioid analgesic therapy (COAT) at the same dose when risk factors for serious opioid induced respiratory depression are present.

Continuing COAT without a safety plan when OUD red flags are present: A patient centered safety-plan must be established if a prescriber is continuing chronic opioid analgesic therapy when red flags are present for Opioid Use Disorder (OUD). For example, red flags for OUD can include a history of overdose known to the prescriber in the past 12 months or a patient's use of opioids in a way which results in neglect of other aspects of their health.

Excessive dosing without responding to evidence of opioid-related harm: Many individual factors heighten the well-documented risks of opioids. Risks increase with opioid dosage. Prescribing more than 400mme per day without an assessment of the risk for opioid-induced respiratory depression, without responding to evidence of opioid-related harm and without mitigating the risk of opioid-induced respiratory depression is contrary to safe prescribing practices.

Discontinuing COAT without providing patient support: Patient support is critical when discontinuing chronic opioid analgesic therapy to mitigate risk to the patient. Discontinuation of chronic opioid analgesic therapy from daily doses greater or equal to 50mme per day without providing patient support creates avoidable risk to patients. Discontinuation may be abrupt or in the form of a too-rapid taper, includes failure to arrange for patient care during periods when the prescribing clinician is unavailable and results in an interruption in care and medical harm.

Failure to participate in the OPIP quality improvement program: Prescribers are identified to participate in OPIP quality improvement program based on annual analysis of the providers' prescribing practices. Under this change providers who are required to participate in quality improvement for two consecutive calendar years and who fail to submit any of the requested information or to communicate with DHS about participation shall be referred to the OIG for investigation.

In instances where providers are identified as prescribing in a manner that inconsistent with any or all of the above community standards, that provider will be referred to the OIG for investigation. Additionally, if during an existing investigation, the OIG identifies a provider who prescribes in a manner inconsistent with these community standards, such prescribing may be sanctionable.

Potential forecast impacts are possible, as some providers may receive sanctions as a result of these guidelines.

This proposal also requests funds to contract with clinical professionals who will advise on quality improvement activities. This will allow OPIP to ensure its quality improvement efforts are based in clinical best practices and allow prescribers completing quality improvement projects to receive feedback from experts in their field.

Impact on Children and Families:

The OPIP is one of Minnesota's strategies to prevent and reduce OUD. In 2021, an average of four Minnesotans died each day from a drug overdose, with the total annual number of drug overdose deaths increasing 22 percent increase from the previous year.[1] OUD brings chaos into the lives of the patient and the patient's children, parents, and other family members. This devastation can be seen in disproportionate rates of justice involvement and child protection services, among many other impacts. Prevention and improved treatment of OUD helps stabilize patients' lives, leading to improvements in their families' lives, as well.

The link between prescribed opioids and illicit use of opioids is increasingly understood. For example, legitimate opioid use before high school graduation is independently associated with a 33 percent increase in the risk of future opioid misuse after high school. This association is concentrated among individuals who have little to no history of drug use and, as well, strong disapproval of illegal drug use at baseline.[2] The National Institute on Drug Abuse summarized the literature in its January 2018 report, "Prescription Opioids and Heroin Research Report."[3]

Equity and Inclusion:

In 2018, the drug overdose mortality rate in Minnesota was ranked eighth lowest in the nation. However, Minnesota ranked first (worst) when measuring the disparity rate ratio of drug overdose deaths among Native Americans relative to whites, and second among African Americans relative to whites. In 2019, Native Americans were seven times more likely to die from a drug overdose than whites; African Americans were two times more likely to die from a drug overdose than whites. The drug overdose mortality rate disparities in Minnesota have worsened, specifically for Native Americans. The 2019 rates were 93.7 per 100,000 residents for Native Americans; and 29 per 100,000 residents for African Americans. The rate for whites is 12.6 per 100,000 residents.

OPIP is designed to help prescribers implement best practices for prescribing regardless of the race or ethnicity of the patient. By helping prescribers implement best practices in this space it can help minimize the impact of implicit bias when prescribing. Available evidence indicates that most individuals who use opioids illicitly first encounter opioids through a prescription either for themselves or others. Additionally, OPIP has specifically partnered with ECHO training programs that include content about disparities and historical trauma and the importance of culturally responsive care when prescribing opioids.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:

This proposal does not directly impact counties.

IT Costs

This proposal does not have an IT component.

[1] Minnesota Department of Health, Preliminary 2021 Overdose Mortality data, 10/5/2022.
[2] Miech R, Johnston L, O'Malley PM, et al. Prescription opioids in adolescence and future opioid misuse. Pediatrics 2015; 136(5) www.pediatrics.org/cgi/doi/10.1542/peds.2015-1364.
[3] Report available at https://nida.nih.gov/download/19774/prescription-opioids-heroin-research-report.pdf?v=fc86d9fdda38d0f275b23cd969da1a1f.

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of providers required to participate in quality improvement activities.					
Results	Number of providers prescribing opioids who are doing so in a manner consistent with community standards and are not required to participate in quality improvement activities.					

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
General Fund			136	136	272	136	136	272
HCAF								
Federal TANF								
Other Fund								
Total All Funds			136	136	272	136	136	272
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	13	HCA Admin - Contract	200	200	400	200	200	400
GF	REV1	FFP @ 32%	(64)	(64)	(128)	(64)	(64)	(128)
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

Minnesota Statutes, section 256B.0638

Change Item Title: 24 Month Time Period for Medical Assistance Supplemental Payments Information

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
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**

Recommendation:

The Governor recommends establishing a 24-month time limit for providers eligible for some supplemental payments to provide DHS the necessary information to calculate those payments in order to align with the original legislative intent of these payments. This proposal is budget neutral.

Rationale/Background:

The Department of Human Services (DHS) is required by state statute to make annual supplemental Medicaid payments to certain state, county, or city-owned providers (Minnesota Statutes, section 256B.196). The supplemental payments for ambulance, anesthesia, dental, physician, and practitioner services are computed as the difference between the Medicaid payment from DHS and the average commercial payer rates for each provider receiving the supplemental payment. In order to calculate the payment amount in accordance with CMS requirements, DHS needs to obtain the commercial payer rates, by procedure code, for the provider's top five commercial payers. Most providers can produce the rate information in a timely fashion so that the supplemental payments can be made within the calendar year to which they are attributable. However, some providers, despite working with DHS for several years, have been unable to produce the needed rate information within a practicable time period.

The length of the delay in being able to compute and execute the payment imposes an administrative burden on DHS staff. In addition, because of the long delay, there is a risk that CMS may refuse to provide the federal matching funds when the payment is finally executed. This proposal would require providers to submit the required information within the 24-month deadline or forgo the supplemental payment for that year. The 24-month period strikes a balance between the needs of the provider and a reasonable timeframe for completing the annual payments.

Proposal:

This proposal establishes a 24-month time limit for providers eligible to receive a supplemental payment for ambulance, anesthesia, dental, physician, and practitioner services to provide the required information to DHS. The implementation of this limit will incent the providers who are eligible for supplemental payments to produce the required rate information in a timely fashion, as the legislative intent of the initial change was that the payments are made annually.

Most providers already submit supplemental payment information to DHS within 24 months, but a very small number of providers have been unable to submit the information DHS requires to calculate or remit the payment for four or more payment years. Because these are federal dollars, this provision will not impact the state

forecast. Additionally, almost all providers are currently in compliance, and DHS expects that the small number of other providers will also comply with the new requirement.

Impact on Children and Families:

While this proposal does not directly impact children and families, both providers and enrollees are best served when payment methodologies are fair, transparent, and timely.

Equity and Inclusion:

Both providers and enrollees are best served when payment methodologies are fair, transparent, and timely.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:

This proposal does not directly impact counties.

IT Costs

This proposal does not have IT costs.

Results:

The efficacy of this proposal will be measured by an increase in the number of supplemental payments that are computed and paid out within the calendar year to which they are attributable.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund								
HCAF								
Federal TANF								
Other Fund								
Total All Funds								
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

Minnesota Statutes, section 256B.196

Change Item Title: Changes to Third Party Liability Requirements

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
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**

Recommendation:
The Governor recommends modifying third party liability requirements to comply with federal law. This proposal is budget neutral.

Rationale/Background:
Medical Assistance (MA) is the payer of last resort, and a third party may be liable to pay all or part of the medical costs provided to MA enrollees. Enrollees with third party liability (TPL) must have medical costs covered by TPL paid by those sources before MA pays claims. Third party payers may include, but are not limited to, other health care coverage (i.e., group health plans, COBRA, individual health plans, Medicare), medical support, or other sources such as auto insurance, workers' compensation, or settlements. The 2022 Consolidated Appropriations Act made changes to the TPL requirements for health coverage that is primary to Medical Assistance (MA). Effective January 1, 2024:

- When a liable third party (health coverage that is primary to MA) requires prior authorization for an item or service provided to an MA member, it must accept MA's authorization that the item or service is covered under the state plan as if such authorization were the prior authorization made by the third party for the service or item.
- The third party must respond to MA's inquiry about a claim no later than 60 days after an inquiry.
- The third party must agree not to deny MA claim for failure to obtain prior authorization for the item or service.

Proposal:
This proposal amends state law regarding third party liability to align with the new requirements of the 2022 Consolidated Appropriations Act. As this proposal is related to prior authorization and response times, any utilization impacts are considered to be secondary.

Equity and Inclusion:
This proposal is for federal compliance and does not directly impact equity.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:

This proposal does not have an impact on counties.

IT Costs

No IT changes are anticipated as a result of this proposal.

Results:

Because this proposal complies with federal law, the end result will be that Minnesota's health plans comply with the requirements of the Consolidated Appropriations Act.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund								
HCAF								
Federal TANF								
Other Fund								
Total All Funds								
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Change Item Title: Minnesota Health Care Programs Enrollee Error Overpayment Cleanup

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
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**

Recommendation:
The Governor recommends amending state law to remove the authority for the Department of Human Services (DHS), counties, and tribes to recover overpayments as a result of client error. The cost of this proposal is indeterminable.

Rationale/Background:
Under Minnesota Statutes, section 256.01, subdivision 2, paragraph (s), the Department of Human Services (DHS) must require county agencies to identify overpayments, establish claims, and utilize all available and cost-beneficial methodologies to collect and recover these overpayments in Department-administered human services programs. An enrollee error overpayment occurs when an enrollee receives more Medical Assistance or MinnesotaCare benefits than they were entitled to because of incorrect or unreported information that does not rise to the level of fraud, theft, or abuse. Current state law lacks specificity on how to assess and recover an overpayment of Medical Assistance or MinnesotaCare benefits resulting from enrollee error, and county and tribal agencies have long been asking for clarification of these policies and procedures.

Recent guidance from the Centers for Medicare and Medicaid Services (CMS) has determined that such recoveries violate a client's procedural right to due process rights ((excepting recoveries for benefits received during the pendency of an unsuccessful appeal of an adverse eligibility determination).

Proposal:
This proposal amends state law to remove the authority allowing for the assessment of overpayments in Minnesota Health Care Programs (MCHP) that are due to enrollee error, except for recovery of benefits continued during the pendency of an unsuccessful appeal.

Counties are responsible for identifying overpayments, establishing claims, and collecting and recovering overpayments as outlined in state law. DHS does not have information on the rate of overpayments that are currently recovered, so the impact for this change is indeterminable.

Impact on Children and Families:
Under this proposal, Minnesota Health Care Program enrollees would no longer be assessed client error overpayment outside of the appeal context. This will modify the way in which overpayments are assessed so that families with already limited resources are not penalized financially due to errors.

Equity and Inclusion:

By rolling back efforts to recover money from MHCP clients for mere error, populations eligible for MA and MinnesotaCare will be at less financial risk for participating in a public health care program. Further, by streamlining activities around these overpayments and clarifying authority and instructions, counties will be more consistent with their recovery activities, resulting in a more equitable impact. Consistent treatment of enrollee error overpayments statewide reduces disparities between localities when human services agencies attempt recovery.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

While not a substantial effect, tribal workers will no longer have to administer the complex work for these recoveries. For the tribes that have been assessing these overpayments, which not all tribes have been doing, there may be a minimal reduction in recovered funds affecting their budget. (*Note: The collection of overpayments has been suspended during the federal public health emergency (PHE) for COVID-19.)*

Impacts to Counties:

County workers will no longer have to administer the complex work for these recoveries. For the counties that have been assessing these overpayments, which not all counties have, there may be a reduction in recovered funds affecting their budget. (*Note: The collection of overpayments has been suspended during the federal public health emergency (PHE) for COVID-19.)*

IT Costs

There are no IT costs associated with this proposal.

Results:

Enrollee error overpayments are assessed at the county level. While it is unclear what the magnitude of outcomes this change will result in, it is expected that the number of overpayments assessed due to enrollee error will decrease.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund								
HCAF								
Federal TANF								
Other Fund								
Total All Funds								
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

Minnesota Statutes, section 256.01, subdivision 2

Change Item Title: Rate Increase for Reproductive Health Services in Minnesota Health Care Programs

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	132	301	331	335
Revenues	0	0	0	0
Other Funds				
Expenditures	26	58	65	68
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	158	359	396	403
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends increasing provider rates for reproductive health services in Medical Assistance (MA). This proposal would require an investment of $516,000 in the FY2024-2025 biennium and $798,000 in the FY2026-2027 biennium.

Rationale/Background:

Base rates for most outpatient services were established prior to 2010 and many are based on submitted charges from the late 1980s and early 1990s. Payments for physicians and other health care professionals are outdated and DHS has no authority to adjust for changes in inflation, wages, or other health care market forces. In addition, because many rate methods reflect the era in which the service was first covered without consideration of the rates of other services, the current system has a patchwork of rates that lack consistency when comparing provider requirements, facility requirements, overhead costs, risk of fraud and abuse, and how well the rates promote policy initiatives and health outcomes.

Additionally, very few rates have been rebased since they were originally established so over time fail to reflect current health care practices and cost drivers The varying ages and lack of consistency between the rate methods also have caused compression within the rates structures creating instances where a highly technical service that can only be rendered by a highly skilled licensed provider may in some cases receive a payment rate that is not that much different than a service that requires much less skill and training. Rates paid for reproductive health are paid using the resource based relative value system (RBRVS) which was implemented in a budget neutral manner. Each year when updates are made by Medicare to DHS modifies the rates to maintain a similar cost pool that was identified in 2010. DHS supplements the payment rates when reproductive health services are delivered in Family Planning or Community clinics but those supplements cannot address the low reimbursement rates across the provider system.

Proposal:

Effective January 1, 2024, this proposal increases the MA payment rates for all reproductive health services by 10%.

Impact on Children and Families:

Reproductive health services are vital services to ensure that individuals who may become pregnant can remain healthy and have families on the timelines they desire. Increasing provider rates for these services may ensure that more enrollees are able to access this care.

Equity and Inclusion:

Marginalized communities are disproportionately enrolled in Medical Assistance when compared to their presence in the overall population. Increasing access to reproductive health services will benefit all Minnesotans enrolled in MA.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:

This proposal does not impact counties.

IT Costs

IT systems changes would be required to implement this change in the Medicaid Management Information System, MMIS, which is Minnesota's automated system for payment of medical claims and capitation payments for the Medical Assistance and MinnesotaCare programs. These systems changes are estimated to require 110 hours of work, take approximately 1 month to complete, and cost a total of $25,500 for initial development. State share is assumed at 29%.

Results:

This proposal aims to provide better access to needed health care services for birthing persons.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			132	301	433	331	335	666
HCAF			26	58	84	65	68	133
Federal TANF								
Other Fund								
Total All Funds			158	359	517	396	403	799
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	33ED	MA Grants	2	5	7	6	6	12
GF	33AD	MA Grants	8	19	27	20	21	41
GF	33FC	MA Grants	114	275	389	303	306	609
HCAF	31	MinnesotaCare Grants	26	58	84	65	68	133
GF	11	State share of systems costs	8	2	10	2	2	4
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

Minnesota Statutes, section 256B.0625, subd. 3

Change Item Title: Rate Methodology for Long-Term Acute Care Hospitals

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
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**

Recommendation:

The Governor recommends updating the payment rate methodology for long-term acute care hospitals (LTACHs) to ensure these payment rates continue to keep pace with increases in hospital costs. This fiscal impact of this change is indeterminable.

Rationale/Background:

In 2013, the Department of Human Services (DHS) began working with the legislature to update all payment rates for inpatient hospital services. The original legislative updates included placeholder language for both critical access hospitals (CAHs) and long-term acute care hospitals (LTACHs). The rate methodology for CAHs was codified in 2015. At that time, the existing LTACH rates provided sufficient cost coverage and were maintained over multiple rebasing periods. LTACHs are the only hospital type whose updated rate methodology is not currently included in statute. This proposal would implement a new rate methodology for the LTACHs but would also ensure that the new methodology would not result in a rate reduction from the existing rates.

Proposal:

This proposal will implement a new rate methodology for the long-term acute care hospitals (LTACHs). The proposed rate methodology will mirror the current rate methodology for CAHs. Those LTACHs that would see a rate decrease from the new methodology will be held harmless; rates for those providers will freeze at their current level until the new rate methodology, which includes inflationary increases, rises to current levels of reimbursement.

DHS is unable to calculate a forecast estimate for this proposal because of the shifting provider landscape in this area. Some providers will see a rate increase under this proposal, and others will see their rates remain stable.

Impact on Children and Families:

Minnesota residents are served by three LTACHs: one in Minneapolis, one in Fargo, North Dakota and one in Sioux Falls, South Dakota. These hospitals specialize in complex cases usually involving a brain injury or the need for long term ventilator support. Although the number of admissions to these hospitals is low (less than 100 per year for the Minnesota hospital and less than five per year for the out of state hospitals), the services they provide are essential for the patients that need them. While this proposal does not directly impact children and families, it is important to ensure a rate methodology is in place to support the cost of providing services to families and children enrolled in MA. Both providers and enrollees benefit when rates are transparent and fair.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
This proposal does not impact counties.

IT Costs
No systems impacts are anticipated as a part of this proposal, as these are per diem rates that are manually entered into MMIS.

Results:
The purpose of the proposed payment rate is to adequately reimburse providers for long term acute care hospital service and ensure that Minnesota Health Care Program enrollees continue to have access to these services when needed.

To determine if the rate change has the desired result, the number of admissions to the long-term acute care hospitals will be monitored. If the admissions rate does not fall faster than fee for service hospital admissions in general, we will conclude that access has been maintained.

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Annual number of admissions to LTACHs	100-200	Sept. 2022			

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund								
HCAF								
Federal TANF								
Other Fund								
Total All Funds								
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):
Minnesota Statutes, section 256.969

Change Item Title: Medicaid Management Information System Modernization

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	14,141	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)	14,141	0	0	0
FTEs	**8**	**0**	**0**	**0**

Recommendation:

The Governor recommends investing $14.1 million in FY 2024 for new planning, development, and technical contracts to enhance, modernize, and stabilize the functionality of Minnesota's Medicaid Management Information System (MMIS), the system that ensures more than 1.4 million people on the Medical Assistance (MA) and MinnesotaCare programs get necessary services and benefits when they need it and supports payments to providers and managed care organizations.

Rationale/Background:

At the most basic level, the Medicaid program exists to pay for medically necessary covered services provided to people on public health care programs. The Medicaid Management Information System (MMIS) is the system that makes direct payments to providers for the full array of covered services and pays managed care organizations to provide services to enrollees which total more than $9 billion annually. MMIS also manages payment rates, coordination of benefits, third party liability when enrollees have other coverage, expenditures for budgeting, financial and quality reporting, and is the system responsible for drawing down the federal dollars that account for more than half of the state's Medicaid program funding.

MMIS was first developed in the early 1970s and then updated in the 1990s using a computer programming language (COBOL) that has been considered obsolete for well over a decade. Aging technology coupled with years of obsolete payment rules and processes results in a system that lacks the agility to make changes needed to support the delivery of health care, increases risk for inaccurate payments, increases administrative cost for providers, and contributes to delays in accessing critical health care services and benefits, which can disproportionately impact certain racial and geographic groups.

The costs for design, development, and implementation of new MMIS components that adapt to provider needs and responds to emerging federal and state requirements have grown past what the Department is currently able to sustain within existing funding. Providers are spending more funds trying to get correct payments from DHS, which takes resources away from patient care and creates incentives for providers to do less business with Medicaid and serve less people on the Medicaid program.

Meanwhile, technical limitations hinder many current and planned functionalities, which affect county, tribal, and state workers using MMIS to develop service agreements, respond quickly to authorization requests for prescriptions and other health care services, update rates timely, process claims accurately, and generate comprehensive reporting and data needed to effectively operate our MA program. These limitations also impact the providers of these services. Relying on an outdated IT platform for our MA coverage program results in:

- Delays in needed care and confusion for enrollees and their families;
- Decreases in the funding providers have available to invest in delivering essential, quality services for some of Minnesota's most vulnerable individuals;
- Challenges maintaining program integrity and preventing fraud, waste, and abuse, and;
- Risk for noncompliance with federal laws which can jeopardize the state's federal Medicaid funding.

The current MMIS does not fully support business needs, requires too many manual workarounds, and requires significant resources to update the system based on changes to state and federal laws. Recent audit findings, Operation Swiss Watch findings and media stories reflecting outdated government IT systems illustrate the results of failing payment systems. Stabilizing and improving Minnesota's MMIS provides an opportunity to enhance the future of MA service delivery for our citizens, DHS partners, and workers who assist our members to manage their MA benefits.

MS supports federal funding opportunities for modernization of the state's MMIS. The state is able to claim a 90 percent federal match for systems design, development, and implementation activities for Medicaid IT systems, meaning the state only has to cover 10 percent of costs. Modernization also allows the department to claim a higher match for sustaining certified MMIS components, thus decreasing our ongoing cost of ownership. These strategic investments will, over time, help improve health outcomes for enrollees while increasing the value of the technology the state is buying for its investment.

Proposal:

This proposal will allow the Department to stabilize, enhance and begin to transform Minnesota's core MA coverage and payments systems. Part of this proposal invests in modernizing foundational components of MMIS, while the second part of the proposal makes strategic and necessary investments in the current MMIS so that it can stay functional through the full launch of the modernized MMIS.

The funding to design, develop, and implement modernized modules of MMIS will set Minnesota on a better trajectory to modernize its entire MMIS, something that numerous states have already done or will be completing in the next few years. While the funding in this proposal will not cover all of the state share required to fully modernize MMIS, it will enable continuation of investments and gains already made and make clearer the trajectory and path for Minnesota to eventually have a fully modernized MMIS. The specific results of modernization elements included in this proposal are as follows:

- Minnesota Provider Screening and Enrollment module: This project has deployed and will refine a web-based Medicaid provider enrollment application and automation of the CMS-required provider screening process and reporting functionality. The project also will assume some development of a more robust provider directory that meets some requirements of the CMS Interoperability Rule. The State will experience a reduced number of provider calls to the call center due to data entry errors that cause billing delays or errors. Additionally, this module will reduce the amount of time a provider request takes overall to receive and accurately process, because the need to fax will be eliminated and less information will be manually entered by State staff.
- Pharmacy claims and benefits management module: This project will contract with a vendor to process outpatient pharmacy claims and manage the outpatient fee-for-service pharmacy benefit. This solution will improve beneficiary experience by aligning customer service with pharmacy hours of operation and reducing delays in getting needed drugs. Additionally, this solution will improve drug rebate collection which totals around $100M annually. Infrastructure assessment and technical advisory services: The State will hire consultation services to analyze the current MMIS infrastructure and functionality, in order to advise on the technical and planning gaps needed in a modernized MMIS. The recommendations from this infrastructure assessment will be used to establish a strategic plan for the configuration, requirements and trajectory of the modernized MMIS, building on the existing initiatives. Technical and planning expertise will also be used through the foundational stages of the planning of modules and the overall modernization initiative. These technical advisory services will aid the State in determining the proper

specifications that will align best with the modernized modules that are already in development and fit the unique needs of Minnesota's MA program.

- Strategic redesign and implementation of components of the claim system: The technical advisory services will aid in mapping a modernized claims system's functionality and integration with other MMIS subsystems. This module will develop priority functionalities of a modernized claims system that will optimize other modernized modules and contribute to greater automation, flexibility, and program integrity. The claims system has significant impact on providers and managed care organizations, so issues involving claims result in high levels of disruption to provider revenue, ability for enrollees to receive timely services, and payment errors that can impact the state's federal Medicaid funding. The ability to make changes quickly and accurately is essential.
- Third party liability case management module: This project modernizes the existing MMIS Third Party Liability (TPL) subsystem by developing a case management system with enhanced claims search functions, financial adjustment and tracking functionality and a connection to the electronic document management system. The first phase creates a case management system for tort recovery that will translate to other legal and financial cases. This system will have a partner portal, online form submission for members, and county access and oversight functions. The State will experience increased accuracy in MA recoveries and program integrity due to efficiencies in the process, decreased case management and processing time, and equitable administration across all TPL programs.
- System and data integration: This project will contract with a vendor that can provide services to support Minnesota in leveraging, sequencing and integrating the variety of products that will constitute the modernized MMIS so that they interface with one another, exchange and make available needed data, and ensure a smooth rollout. This platform will result in a solid technical base from which to connect all modernized MMIS modules, the data that flows through the system, and ensure a consistent user experience when crossing between different MMIS modules/subsystems.

The broader MMIS modernization initiative will result in enhanced and updated functionality by:

- Redesigning, simplifying and integrating payments for Medicaid benefits;
- Enabling more timely, transparent and responsive communication with providers and managed care organizations;
- Allowing people served greater access to the information about their services so that they can be more informed while making health care decisions
- Empowering DHS, local agencies and contracted partners to continually identify, analyze and streamline payment processes to improve the wellbeing of the people we serve;
- Ensuring that data about payments, providers, rates and quality is more accessible and usable;
- Supporting DHS efforts to advance equity and reduce disparities by ensuring that a modernized Medicaid benefits delivery and payment system can help identify gaps in service delivery that prevent equitable access to Medicaid; and
- Improving the availability, transparency and use of Medicaid financial data to the federal government and our other partners in benefit design and service delivery.

The funding to stabilize and sustain the current MMIS will:

- Identify and obtain the hardware and software upgrades strategically necessary to maintain functionality of components of the existing system;
- Implement and operationalize new components of the almost fully modernized Minnesota Provider Screening and Enrollment (MPSE) module that has been developed within the State to improve the provider enrollment experience, and;
- Develop and deploy security risk reduction upgrades, identity and access management upgrades, as well as to move MMIS-related Java applications to the Cloud.

Impact on Children and Families:

Children and families are key beneficiaries of the state's MA program, and, currently, one in four Minnesotans is served by MHCP. MA has a central role in supporting the administration's priority to ensure children have a healthy start and can access necessary health care services. People enrolled in MA and MinnesotaCare rely on a broad range of services and benefits to support their health for a fuller life at a lower cost, so that they can achieve their highest potential. MMIS is the central information system that supports enrollee's access to these essential services and benefits. Investing in a modernized MMIS will benefit children and families enrolled in MA and MinnesotaCare by delivering quality, coordinated care, offering enhanced reporting and sharing data and information capabilities, and ensuring program integrity. For example, the following are just a few examples of how a modernized MMIS would contribute to increased quality care for people served:

- A modernized Pharmacy prior authorization system and increased call center coverage will reduce delays in accessing essential medications, so enrollees no longer experience disruptions in their drug therapy or non-compliance with their medication regimen, providers will have less administrative work, and the state will benefit from more timely and accurate collection of drug rebates, which total around $100 million annually.
- People served and their providers will have greater access to key information about their healthcare, so that the provider can better coordinate and integrate a patient's care and patients can engage more effectively and have a role in the coordination of their own services.
- Modernized IT solutions allow for automation and oversight, which reduces errors that lead to provider frustration and can impact their relationship with MA patients. Modernized systems will increase transparency so people will receive and hear about effective, fair, equitable services from MA, which will increase the likelihood they will engage with services and trust providers.

Equity and Inclusion:

Medical Assistance and MinnesotaCare cover the state's most vulnerable populations, including nearly 40 percent of the state's children. Additionally, 51.1 percent of African Americans and other Minnesotans of color get their health care through MHCP, compared to 34 percent of white Minnesotans. MMIS enables DHS to operate as an independent fee-for-service health plan for people receiving MA, but it lacks some functionalities available in healthcare IT systems for non-Medicaid health plans in Minnesota. A modernized MMIS will support equity in access and outcomes for enrollees by delivering quality, coordinated care, offering enhanced reporting and data-sharing capabilities, and ensuring program integrity. More equitable healthcare outcomes are feasible with a modernized MMIS in the following ways:

- Modernizing pharmacy functions: Drug therapy is a typical component of many treatment plans to manage chronic conditions. Many of these conditions are disproportionately experienced by non-white individuals and contribute to increased mortality rates and decreased quality of life. A modernized prior authorization system and 24/7 call center coverage will reduce delays in accessing essential medications in a timely way, so enrollees no longer experience disruptions in their drug therapy or non-compliance with their medication regimen.
- Interoperability and access to health data: Expanding our compliance and alignment with interoperability data standards will allow MA beneficiaries access to their person-centered, actionable, and usable health information. Healthcare systems have a history of treating people of color unfairly and creating transparency and access to health information is one way to reduce inequities and unfair treatment.
- Pushing out data to providers: The state collects a lot of data to operate and maintain the MA program, but modernized data solutions will allow the state to push out data that is appropriate and useful for providers to deliver quality and coordinated care. This data could be particularly useful for providers serving people who are not already receiving services in a coordinated manner. Historically, people of color are less likely to be enrolled in programs that integrate and coordinate services, such as Minnesota Senior Health Options or Special Needs Basic Care.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Impacts to Counties:

This proposal does not impact counties directly, however, it is possible that counties will experience greater administrative efficiencies from a modernized MMIS that could benefit their workforce, particularly where counties are providing direct health care services to enrollees or where disruptions in care lead to increases in calls to counties from enrollees or where additional county services become necessary due to foregone or delayed care.

IT Costs:

The entirety of this proposal is for information technology investments. The state share will be $14,141,000, and will leverage an additional $62,688,000 in federal funds for a total investment of $76,829,000 in MMIS over the next two federal fiscal years.

Results:

Significant oversight and monitoring will occur over the lifespan of the MMIS modernization initiative. Each MMIS sub-project and related vendor(s) must meet DHS and federal approval prior to starting, and meet federal certification requirements once developed, prior to implementation. DHS will develop rigorous evaluation frameworks and criteria to ensure this investment will result in a more stable, secure and industry-standard technology platform to deliver and pay for covered services of our publicly funded health care programs.

CMS has instituted an outcomes-based certification process for all MMIS modernization projects funded by federal funds. Minnesota engages in planning and tracking throughout the life of all MMIS projects to ensure readiness for CMS's certification reviews. Some metrics that DHS will measure to assess the success of these investments include:

- Reduced billing delays and errors;
- Reduced processing time for provider requests;
- Reduced denied pharmacy claims, and;
- Increased staffing capacity and caseload metrics.

These investments are essential to maintaining participation by providers, keeping healthcare viable in rural areas of the state, and reducing disparities disproportionately experienced by people on public health care programs.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			14,141					
HCAF								
Federal TANF								
Other Fund								
Total All Funds			14,141					
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	State share of systems costs (MMIS)	14,141					
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	HCA FTEs	8					

Change Item Title: Use of Audio-Only Telehealth in MHCP

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	6,197	8,153	1,188	0
Revenues	0	0	0	0
Other Funds				
Expenditures	1,038	1,339	195	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	7,235	9,492	1,383	0
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends extending the authority for the use of audio-only telehealth in Minnesota Health Care Programs (MHCP) through June 30, 2025. This proposal requires an investment of $16,727,000 in FY2024-2025 and $1,383,000 in FY2026-2027.

Rationale/Background:

During the 2021 session, the Minnesota legislature passed a package of telehealth reforms to improve access to health care via telehealth during the COVID-19 pandemic. One component of this package was an extension of the ability for MHCP providers to provide audio-only telehealth during the state peacetime emergency for COVID-19. The ability to provide audio-only telehealth was extended through June 30, 2023 to allow the Department of Human Services (DHS) and the Minnesota Department of Health (MDH) to conduct a study on the use of telehealth and provide the legislature with recommendations around the continued use of audio-only.

The first phase of the joint DHS/MDH report is due by January 15, 2023, with a final report due January 15, 2024, and the language passed in 2021 requires the initial report to contain recommendations around the continued use of audio-only telehealth. However, until national coding updates were made in early 2022, DHS was unable to identify telehealth visits that were strictly audio-only. Due to this, and the continued changes in access to health care as a result of the COVID-19 pandemic, DHS and MDH do not believe there is sufficient data available to analyze the use and effectiveness of audio-only telehealth at this time. As required by the legislature, this report will examine whether audio-only telehealth supports equitable access to health care services and eliminates barriers to care for vulnerable and underserved populations without reducing the quality of care, worsening health outcomes, or decreasing satisfaction with care. An extension of the authority for audio-only telehealth will allow DHS and MDH more time to engage with enrollees, providers, and other stakeholders before making recommendations about ongoing changes.

Proposal:

This proposal will extend the authority for the use of audio-only telehealth in Minnesota Health Care Programs (MHCP) through June 30, 2025 to give DHS and MDH more time to study the impacts and usage of audio-only telehealth and make recommendations for the use of audio-only telehealth going forward. Specifically, studies will continue to assess the clinical outcomes for individuals when served through audio only telehealth.

Costs in this proposal recognize the continued utilization of audio-only telehealth through FY25.

Since the initial release of the Governor's budget, DHS analyzed preliminary data on the volume of audio-only telehealth claims. The costs in this revised proposal reflect this data on actual utilization of audio-only claims.

Impact on Children and Families:

During the COVID-19 pandemic, the use of telehealth, including audio-only telehealth, has helped maintain access to health care for many children and families, particularly for those in rural areas, people who were at higher risk of COVID infection, and people with limited mobility or access to transportation. Extending the allowance for audio-only telehealth, while DHS and MDH continue to analyze its use and effectiveness, will maintain this important access for children and families.

Equity and Inclusion:

During the COVID-19 pandemic, the use of telehealth, including audio-only telehealth, has helped maintain access to health care for many Minnesotans, particularly for those in rural areas, people who were at higher risk of COVID infection, and people with limited mobility or access to transportation. Extending the allowance for audio-only telehealth, while DHS and MDH continue to analyze its use and effectiveness, will maintain this important access for Minnesotans.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

This proposal does not directly impact tribes. However, tribal members will be able to continue to use audio-only telehealth to access health care.

Impacts to Counties:

This proposal does not directly impact counties.

IT Costs

No IT costs are anticipated as part of this proposal.

Results:

This proposal will extend the time period that DHS and MDH have to conduct their analysis of the use of audio-only telehealth to ensure that the recommendations for continued use are accurate and consider the impacts for both providers and enrollees.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			6,197	8,153	14,350	1,188		1,188
HCAF			1,038	1,339	2,377	195		195
Federal TANF								
Other Fund								
Total All Funds			7,235	9,492	16,727	1,383		1,383
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	33ED	MA Grants	2,791	3,675	6,466	535		535
GF	33AD	MA Grants	275	355	630	52		52
GF	33FC	MA Grants	3,131	4,123	7,254	601		601
HCAF	31	MinnesotaCare Grants	1,038	1,339	2,377	195		195
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

Laws of Minnesota 2021, Chapter 7, Article 6, Section 26
Minnesota Statutes, section 62A.673, subd. 2, paragraph (h)

Change Item Title: Direct Care and Treatment Maintain Current Service Levels

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	57,813	81,456	81,456	81,456
Revenues	(16,539)	(23,052)	(23,052)	(23,052)
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	41,274	58,404	58,404	58,404
FTEs Maintained	**405**	**547**	**547**	**547**

Recommendation:
The Governor recommends additional funding of $57.8 million in FY 2024 and $81.4 million in each subsequent year from the general fund to maintain the current level of service delivery within the Department of Human Services (DHS) Direct Care and Treatment (DCT) services.

Rationale/Background:
Each year, the cost of doing business rises—employer-paid health care 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.

DCT is a large, specialized behavioral health care system operating 24 hours a day, 365 days a year. Personnel costs make up more than 85 percent of the total operating expenditures. When faced with fiscal pressures outside its control, the only cost-containment recourse DCT has is to hold positions open, which in turn reduces the ability to serve patients and clients systemwide. As a highly regulated health care system, DCT cannot operate programs without sufficient staffing to provide safe and effective treatment. To do so invites sanctions and penalties from state and federal regulators. Without an increase in base funding, DCT will have no choice but to scale back and/or suspend services.

Proposal:
The Governor recommends increasing agency operating budgets to support maintaining the delivery of current services. For DCT, this funding will cover increases in compensation and insurance costs, as well as cost increases in food, drugs, medical supplies, building maintenance and repairs, utilities, professional services contracts, and all other costs associated with operating a health care system 24 hours a day, 365 days a year

Results:
This proposal is intended to allow DCT to continue to provide current levels of services to approximately 12,000 individuals with mental illness, substance use disorder and developmental disabilities at a time when there is extreme pressure to treat more and more individuals.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			41,274	58,404	99,678	58,404	58,404	116,808
HCAF								
Federal TANF								
Other Fund								
Total All Funds			41,274	58,404	99,678	58,404	58,404	116,808
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	61	MHSATS	20,421	28,286	48,707	28,286	28,286	56,572
GF	62	CBS	1,693	2,471	4,164	2,471	2,471	4,942
GF	63	Forensics	15,509	23,002	38,511	23,002	23,002	46.004
GF	64	MSOP	14,248	20,054	34.302	20,054	20,054	40,108
GF	65	DCT Admin/Support	5,942	7,643	13,585	7,643	7,643	15,286
		Total Expenditures	57,813	81,456	139,269	81,456	81,456	165,912
GF	Rev2	Cost of Care Collections	(16,539)	(23,052)	(39,591)	(23,052)	(23,052)	(46,104)
		FTEs Maintained						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	61	MHSATS	145.03	191.37		191.37	191.37	
GF	62	CBS	13.48	18.56		18.56	18.56	
GF	63	Forensics	109.47	155.79		155.79	155.79	
GF	64	MSOP	106.33	142.53		142.53	142.53	
GF	65	DCT Admin/Support	31.60	39.22		39.22	39.22	
			405.91	547.47		547.47	547.47	

Change Item Title: Direct Care and Treatment Electronic Health Record System

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	6,680	19,241	10,660	11,580
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	6,680	19,241	10,660	11,580
FTEs	**30.0**	**41.0**	**42.0**	**51.0**

Recommendation:

The Governor recommends appropriating $25.9 million in the FY 2024-25 biennium for additional components and infrastructure to fully implement an integrated Electronic Health Record (EHR) system across all Direct Care and Treatment (DCT) programs. This proposal is to implement a comprehensive, integrated and interoperable EHR system that will improve patient care and safety across the entire state-operated behavioral health system and put DCT in compliance with state regulations that have been in place for nearly a decade.

The EHR will:

- Make comprehensive patient health records quickly accessible to clinical staff who treat patients at all DCT facilities, an essential tool for safe and effective treatment that has long been a standard of care in other health systems.
- Make it possible for community hospitals, clinics and other care providers outside of DCT to quickly access important patient records when treating DCT patients at their facilities, a standard expectation of every health system that DCT is unable to meet.
- Allow patients and their guardians ready access to their own health information. Failure to provide such access is a violation of patient rights. Patient and will have more choices for using, sharing and manage their medical record and collaborating with health care providers.
- Put DCT in line with state regulations with which it has been out of compliance since 2015.

This proposal will provide the funding needed to meet regulatory requirements and demonstrate successful outcomes by July 2027.

Rationale/Background:

In 2008, the Minnesota Department of Health (MDH) required health care facilities and providers to implement EHR systems by 2015. Nearly a decade since the deadline, 98 percent of Minnesota's other health care systems have fully implemented EHR systems that meet state regulatory requirements. However, the state-operated behavioral health care system still does not meet this mandate because it has not received sufficient funding to fully implement an EHR system. To date, the system remains an inadequate patchwork of electronic and paper records and is far from being fully implemented.

The heavy reliance on paper records greatly impacts DCT's ability to provide accurate, timely and complete information to both DCT clinicians and outside health care entities. DCT has more than 300,000 filing inches of paper medical records and more than 100,000 patients with digital records in the current limited system. Operating dual paper and electronic systems is staff intensive, inefficient, and creates an unsafe disjointed

medical record. An annual review for a single Forensic Services patient requires medical staff to examine electronic forms and records, plus four large binders on the patient's treatment unit, plus three boxes of records in storage. If the patient has moved between any of the 200 DCT sites around the state, a comprehensive annual review is impossible to complete. That leads to care decisions that may not be based on a full understanding of the patient's history.

Comprehensive health history for all patients and clients should be available electronically.

Safe, effective, high-quality care: An EHR system is an essential tool for patient care. To provide the safest, most effective treatment, clinicians *must* have a complete understanding of a patient's medical conditions and treatment history, treatment plans, ongoing assessments, medication administration, and more, all of which impact treatment and health outcomes. Currently, DCT cannot effectively track basic patient health information. Doctors are forced to keep spreadsheets of routine things such as immunizations, colonoscopies, and mammograms. This is inefficient and creates unsafe practices.

Information sharing: Access to comprehensive patient information is not only vital for clinicians in DCT facilities, but also is equally important for community-based health care providers who treat DCT patients and clients. DCT routinely refers patients to outside health care entities for emergency services, health care appointments, and specialty care. This funding proposal will allow DCT to develop patient portals that enable community providers to access necessary information to ensure continuity and consistency of care at times when patients are being treated in outside facilities for acute conditions or once they have been discharged from DCT facilities and will continue treatment in communities where they live. In any case, ready access to patient records leads to safer, more effective treatment outcomes and decreases the likelihood of readmission. The comprehensive EHR will ensure continuity of care, medication management, treatment outcomes, and well-informed patient and patient stakeholders, both within DCT facilities and in other clinical and community health care settings, providing better management of underlying acute and long-term medical conditions.

Telehealth: The COVID-19 pandemic greatly increased demand for DCT to provide remote services to patients and clients, an important safety measure that continues to be necessary today, even as the pandemic recedes somewhat. However, without a fully functioning EHR system, telehealth services remain severely limited.

Equity: DCT's limited EHR system makes it nearly impossible to evaluate treatment outcomes from a health care equity standpoint because it does not have the ability to generate population-specific data by race, culture, gender, and other factors. The inability to break out and analyze such data makes it difficult to identify health disparities and to develop more culturally tailored treatments to address them. A fully comprehensive and integrated EHR system contains key functionality that will allow DCT to discover, report and address inequities.

Regulatory compliance: A variety of state and national regulatory entities place requirements and standards on DCT to have a fully comprehensive EHR. Failing to meet these requirements opens DCT up for regulatory citations and penalties and puts patients and clients at risk. As a health care provider, DCT was required to comply with the May 1, 2020, Office of the National Coordinator (ONC) rule, which sets the requirements for Information Blocking as required by Congress in the 21st Century Cures Act. Information Blocking is defined as a practice likely to interfere with access, exchange or use of electronic health information (EHI), except as covered by an exception or required by law. The ONC has defined EHI as data elements represented in the U.S. Core Data for Interoperability (USCDI) during the first 24 months of the rule. A fully functional EHR system would ensure DCT's compliance with this Act.

Proposal:

The proposal seeks to achieve interoperability, data use, platform optimization, and provider and patient experience enhancements. The focus of a fully comprehensive, interoperable EHR during FY 2024-25 will be on platform optimization, clinical/provider and patient experience, and interoperability with other health care

entities, and on managing the data and data usage. DCT will also be integrating telehealth, patient kiosks, and direct messaging.

The proposal seeks to achieve crisis management, population health, implementation of revenue management, and will address the new regulatory requirements around the 21st Cures Act. DCT will also be implementing a comprehensive system for its Community-Based Services division and a dietary solution for the Anoka-Metro Regional Treatment Center to replace the multiple systems used today. The results of this effort will also authorize clinicians involved in a patient care to access the treatment history across the continuum by sharing information with other health care providers outside of the state system.

Impact on Children and Families:

This proposal will provide full capability of the EHR system at the Child and Adolescent Behavioral Health Hospital (CABHH), which is a state-operated psychiatric hospital in Willmar.

Equity and Inclusion:

Implementing this proposal will allow DCT's diversity and equity team to extract and analyze data necessary to conduct equity audits and treatment modality evaluations. BIPOC populations represent a higher percentage of all DCT patients (21 percent) than Minnesota's general population (14 percent). In addition, DCT patients are disproportionally impacted by health inequities, especially BIPOC, because of serious and persistent mental illness and substance use disorders, and because they have more physical health ailments than the average patient. A fully comprehensive, interoperable EHR system will help identify and begin to address those disparities.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:

This proposal is not expected to impact counties, but county case managers and social workers will have the ability to have access based on care responsibility when patents move back into community settings or the next level of care.

IT Costs

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll	$3,545	$5,008	$4,761	$5,603	$5,603	$5,603
Professional/Technical Contracts	$3,135	$14,233	$5,899	$5,977	$4,622	$4,622
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)						

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Total	**$6,680**	**$19,241**	**$10,660**	**$11,580**	**$10,225**	**$10,225**
MNIT FTEs	16.00	16.00	8.00	8.00	8.00	8.00
Agency FTEs	14.00	25.00	34.00	43.00	43.00	43.00

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	% of the Electronic Health Record meeting state and federal laws, regulatory requirements and health care standards	Less than 50%	6/30/22	Less than 50%	100%	6/30/27
Quantity	% of the Electronic Health Records being electronically exchanges with health care entities outside DCT	Less than 5%	6/30/22	Less than 10%	90%	6/30/27
Quantity	% of DCT records that are fully electronic and in the required format to exchange interoperable	Less than 10%	6/30/22	Less than 10%	90%	6/30/27

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
General Fund			$6,680	$19,241	$25,921	$10,660	$11,580	$22,240
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$6,680	$19,241	$25,921	$10,660	$11,580	$22,240
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
	65	DCT Operations – Consulting Services	$3,135	$14,233	$17,368	$5,899	$5,977	$11,876
	65	DCT Operations – Staff Costs	$1,080	$2,543	$3,623	$3,529	$4,371	$7,900
	11	Central IT	$2,465	$2,465	$4,930	$1,232	$1,232	$2,464
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
	65	DCT Operations	14.00	25.00		34.00	43.00	
	11	Central IT	16.00	16.00		8.00	8.00	

Change Item Title: Direct Care and Treatment Program Enhancements

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	8,009	8,009	8,009	8,009
Revenues	(8,009)	(8,009)	(8,009)	(8,009)
Special Revenue Fund 2000				
Expenditures	(1,451)	(1,451)	(1,451)	(1,451)
Revenues	1,451	1,451	1,451	1,451
Enterprise Fund 4101				
Expenditures	(19,315)	(19,952)	(19,875)	(20,163)
Revenues	19,315	19,952	19,875	20,163
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs Maintained/New	**164.5/15.75**	**164.5/15.75**	**164.5/15.75**	**164.5/15.75**

Recommendation:

The Governor recommends enhancing services within the Department of Human Services (DHS), Direct Care and Treatment (DCT) behavioral health system to continue to provide high-quality services to individuals with mental illness, substance abuse disorders and developmental disabilities that community providers cannot or will not serve. Services will be funded with base appropriations reallocated from other programs within DCT.

Rationale/Background:

DCT is a large, highly specialized behavioral health care system that provides care to about 12,000 people a year. Most of the people served by DCT are civilly committed and have complex mental health needs and behavioral challenges. They are individuals who private providers cannot or will not serve. DCT serves a unique role in Minnesota's behavioral health treatment continuum, providing the most specialized services to those with the most complex needs.

DCT operates an extensive statewide network of psychiatric hospitals and other inpatient mental health facilities, substance use treatment facilities, group homes and vocational services for people with disabilities, and special care dental clinics. It also operates the nation's largest program for civilly committed sex offenders.

In order to ensure high-quality patient care, DCT needs stable funding sources to maintain inpatient services and to provide necessary levels of support for patients who are discharged to continue their treatment in communities when those services aren't available from other providers.

Proposal:

This proposal seeks to make investments in enhanced services provided by DCT by reallocating certain funds. The Legislature approved base funding for the Minnesota State Operated Community Services (MSOCS), which was needed to transition the program into a new model of care focused on serving individuals who require a higher level of staffing and services. Funding was provided for anticipated financial losses during the transition. MSOCS is now financially stable and no longer requires the entire base appropriation to sustain services.

DCT proposes reallocating funds to stabilize the Community Addiction and Recovery Enterprise (C.A.R.E.) program by transitioning the funding source from an enterprise service to general fund appropriation. Currently, C.A.R.E. must operate primarily on the revenue collected from services it provides. Most clients served in the program have been civilly committed as chemically dependent but refuse to participate in treatment. DCT cannot bill for services when clients don't participate in treatment, which has led to continued operating losses. Without appropriated funding, DCT will have no choice but to suspend services.

Once patients are discharged from DCT programs, ongoing support is vital for patients and clients to make a stable and successful transition to life in the community. This proposal requests to expand outpatient consultation services to provide additional services to individuals who are discharged. Services include medication management, counseling, and outpatient pharmacy services. These services are key to ensuring continuity of care for individuals and provides the ability to monitor compliance to medication adherence as well as mental stability.

Finally, this proposal seeks the expansion of Community Support Services (CSS) to provide wraparound services for individuals with disabilities in the community through mobile teams located throughout the state. CSS teams work with community providers to help stabilize clients in crisis and keep them in community settings and avoid admission to community hospitals and state-operated treatment facilities. Adding an additional mobile team will assure services are available in more areas of the state.

Equity and Inclusion:

DCT operates an array of residential and treatment programs serving people with mental illness, developmental disabilities and chemical dependency. Many of those DCT serves are also part of one or more of the following groups: BIPOC, people with disabilities, people in the LGBTQ community, other protected classes, and veterans. Throughout this planning process, DCT will ensure equity and inclusion are central to DCT's continued care and services.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:

This proposal is not expected to impact counties.

IT Costs

This proposal has no IT impacts.

Results:

Moving C.A.R.E. to an appropriated funding model will allow the program to operate with more stability and assure staffing and services can continue for the individuals served.

Investing in outpatient services will allow DCT to better support individuals who have been discharged from inpatient treatment. Many clients are unable to find the necessary services to make them successful in the community. These enhanced services will allow DCT to support and monitor individuals and reduce the likelihood of readmission to inpatient programs.

Expansion of the CSS mobile team will help individuals in crisis get the support they need in community settings. This will expand the number of mobile teams from seven to eight, providing greater outstate supports for individuals and providers.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
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 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	61	CARE Operations	2,831	2,156	4,987	2,156	2,156	4,312
GF	65	Outpatient & Consulting Svcs	2,641	3,037	5,678	3,037	3,037	6,074
GF	62	Additional CSS Team	837	1,116	1,953	1,116	1,116	2,232
GF	65	DCT Support Svcs	1,700	1,700	3,400	1,700	1,700	3,400
GF	Rev2	Cost of Care Collections	(8,009)	(8,009)	(16,018)	(8,009)	(8,009)	(16,018)
4101	61	CARE Operating Expense	(19,315)	(19,592)	(38,907)	(19,875)	(20,163)	(40,038)
4101	61	CARE Revenue	19,315	19,592	38,907	19,875	20,163	40,038
2000	65	Outpatient Psych Svcs Expense	(1,451)	(1,451)	(2,902)	(1,451)	(1,451)	(2,902)
2000	65	Outpatient Psych Svcs Revenue	1,451	1,451	2,902	1,451	1,451	2,902
		Net GF Impact	0	0	0	0	0	0
		FTEs Maintained						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	61	CARE Operations	157.45	157.45		157.45	157.45	
GF	65	Outpatient & Consulting Svcs	7.05	7.05		7.05	7.05	
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	65	Outpatient & Consulting Svcs	5.00	5.00		5.00	5.00	
GF	62	Additional CSS Team	10.75	10.75		10.75	10.75	

Change Item Title: DHS Central Office Maintain Current Service Levels

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	15,178	23,737	23,737	23,737
Revenues	0	0	0	0
SGSR				
Expenditures	268	536	536	536
Revenues	0	0	0	0
HCAF				
Expenditures	1,286	2,576	2,576	2,576
Revenues	0	0	0	0
TANF				
Expenditures	990	1,094	1,094	1,094
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	17,722	27,943	27,943	27,943
FTEs	**54.1**	**81.6**	**81.6**	**81.6**

Recommendation:

The Governor recommends additional funding of $15.2 million in FY 2024 and $23.7 million in each subsequent year from the general fund, $990 thousand in FY 2024 and $1.1 million in each subsequent year from the Temporary Assistance for Needy Families (TANF) block grant, $1.3 million in FY 2024 and $2.6 million in each subsequent year from the health care access fund (HCAF) and $268 thousand in FY 2024 and $536 thousand in each subsequent year from the state government special revenue (SGSR) fund to maintain the current level of service delivery within central office at the Department of Human Services (DHS).

Rationale/Background:

Each year, the cost of doing business rises—employer-paid health care 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.

Agencies face challenging decisions to manage these costs within existing budgets, while maintaining the services Minnesotans expect. From year to year, agencies find ways to become more efficient with existing resources. For the Department of Human Services, the following efficiencies have been implemented to help offset rising operating costs:

- The Document Management Unit (DMU) in the Health Care Administration has reduced staffing costs by almost 50 percent through adopting new technologies that increased automation and reduced the amount of information that needs to be manually inputted. The ability to auto read documents alone alleviated over 1,000,000 mouse clicks annually. These changes reduced the number of FTEs in the DMU from 14 to eight.
- The Behavioral Health, Housing and Deaf and hard-of-Hearing Administration (BHDH) designed and implemented a robust system to manage the entire life cycle of contracts—the Contracts Integration System (CIS). The CIS is a central system for all contract documentation (contracts, amendments, OGM documentation, EIORs, and other supporting items) and a workflow approval process system. Currently, BHDH has 800+ contracts in the system and the CIS will be fully operational by December, 2022. DHS

developed, built and is implementing CIS with an in-house team rather than contracting work out to an outside vendor, which has saved as much as $1.4 million, with ongoing savings of $50 thousand per year in maintenance costs.

- DHS has also taken advantage of lessons learned during the pandemic. During COVID, DHS stopped operating its in-person health care customer service center and opted to instead use navigators to provide customer assistance. The Health Care Administration found that it could do this without sacrificing the quality of assistance provided to clients. This change will save approximately $338 thousand per year by reducing seven FTEs and reduced costs for leasing office space.

However, cost growth typically outstrips efficiencies, and without additional resources added to agency budgets, service delivery erodes.

For Department of Human Services, operating cost pressures exist in multiple categories—increases in compensation and insurance costs at the agency, increasing costs to maintain our current staff compliment in a challenging labor market, and increasing IT costs. If an operational increase is not provided, the services Department of Human Services delivers to Minnesotans will be impacted. Some examples of potential impacts include:

- Reduced capacity to support consumers and respond to inquiries and requests for assistance from providers in health care programs
- Potential delays in completing required processes for awarding and issuing grants to community-based organizations, counties and tribal governments
- Increased delays in completing requests for licenses for child care and home and community -based services
- Reduced capacity to complete background studies will result in delays and growing backlogs
- Reduced ability to investigate allegations of fraud in human services programs, which results in lower amounts of recovery revenue from investigations

Proposal:

The Governor recommends increasing agency operating budgets to support maintaining the delivery of current services. For DHS, this funding will cover expected and actual employee compensation growth, cost increases in IT services and postage and printing costs, and increases in professional and technical contracts.

Results:

This proposal is intended to allow DHS to continue to provide current levels of service and information to the public.

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 27-28
General Fund			15,178	23,737	38,915	23,737	23,737	47,474
HCAF			1,286	2,576	3,862	2,576	2,576	5,152
Federal TANF			990	1,094	2,084	1,094	1,094	2,188
SGSR			268	536	804	536	536	1,072
Total All Funds			17,722	27,943	45,665	27,943	27,943	55,885
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 27-28**
GF	11	GF Salary and Operations	9,728	17,816	27,544	17,816	17,816	35,632
HCAF	11	HCAF Salary and Operations	1,891	3,788	5,679	3,788	3,788	7,576
GF	11	Systems Account IT	8,563	11,622	20,185	11,622	11,622	23,244
SGSR	11	SGSR Salary and Operations	268	536	804	536	536	1,072
TANF	12	TANF Salary and Operations	990	1,094	2,084	1,094	1,094	2,188
HCAF	REV1	Health Care Access Fund FFP@32%	(605)	(1,212)	(1,817)	(1,212)	(1,212)	(2,424)
GF	REV1	General Fund FFP@32%	(3,113)	(5,701)	(8,814)	(5,701)	(5,701)	(11,402)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 27-28**
GF	**11**		43.72	65.08		65.08	65.08	
HCAF	**11**		5.71	10.81		10.81	10.81	
SGSR	**11**		0.85	1.60		1.60	1.60	
TANF	**12**		3.78	4.10		4.10	4.10	
All Funds			54.06	81.59		81.59	81.59	

Change Item Title: Continuous Improvement and Compliance Expansion

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	2,046	4,108	4,126	4,126
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	2,046	4,108	4,126	4,126
FTEs	**21**	**38**	**38**	**38**

Recommendation:

The Governor recommends investments in continuous improvement resources that will increase efficiency and reduce waste as well as to address gaps in centralized business functions that are contributing to audit findings. This investment will allow DHS to meet the increasing internal demand for continuous improvement expertise and to staff critical internal control functions.

This proposal also provides administrative resources to make changes in the grant-making process to allow for better, quicker distribution of funds to smaller entities and culturally specific organizations. This proposal funds a central grants office that would 1) utilize a deliverable-based approach to contracts; 2) implement version control utilizing a Contracts Integration System (CIS); and create an external-facing RFP system and process for interaction wtih grantees.

Rationale/Background:

DHS serves the state of Minnesota's most vulnerable citizens in an environment of increasing demand for services, increasing programmatic complexity, and changing technological requirements.

DHS has an annual budget of over $22 billion and serves over 1.5 million Minnesotans. Federal laws related to Medicaid and other human services programs are complex, and the department is frequently required to make adjustments to conform to changes in state laws, federal regulations and guidance. DHS works to ensure that state and federal taxpayer dollars are spent efficiently and in compliance with state and federal laws. The department promotes continuous improvement and accountability across essential human services in all 87 counties and 11 Tribes across the state.

Over the last few years, DHS and regulators have identified and brought forward several payment errors and compliance issues related to various programs operated by the Department. In August 2022, the Office of the Legislative Auditor (OLA) released a special review of Homelessness and Housing Grants, finding that DHS' internal controls were not adequate, and that DHS did not comply with Office of Grants Management (OGM) requirements. The OLA conducted a similar assessment of Behavioral Health Grants in March 2021, with similar findings related to DHS' internal controls and compliance requirements. In 2019, the OLA released a special review of Payments for Self-Administered Opioid Treatment Medication that found DHS made payments without legal authority and without the processes and rationale for decisions documented.

DHS is taking several steps to centralize its contracting and grants processes and improve process controls to ensure that services and programs are in compliance with state and federal laws and Office of Grants

Management (OGM) requirements. DHS recently completed a thorough assessment of its grants and contracting process. In evaluating processes and working to resolve these issues, DHS has determined there is a critical need for additional resources to further strengthen continuous improvement and internal control efforts and to ensure that DHS continues to be good stewards of taxpayer dollars.

Administrative overhead costs for DHS have consistently remained at or below three percent of the overall agency budget, which is well below administrative overhead for other state and federal agencies and other organizations with similar missions. The department has made dramatic improvements to financial controls and program oversight over the past several years while maintaining its low overhead. However, as the programs and budget overseen by DHS have increased in terms of size and complexity, it is important that investments be made in compliance, finance and continuous improvement resources to enable DHS to continue the progress is has made thus far and continue to be a trusted steward a public resources.

Proposal:

This proposal addresses immediate and critical needs by increasing the capacity of the continuous improvement, contract compliance and grants oversight, and financial operations offices. This increased administrative capacity will be used to expand and improve programmatic controls, fiscal oversight, and increase process efficiency for the people and taxpayers the agency serves. The 33 positions funded through this proposal will be phased on over the course of FY 2024, based on priority, and will be in place by July 1, 2024.

Strengthening Continuous Improvement (9.0 FTEs)

Effective business process management allows for consistent process documentation and increased transparency – both of which are needed for continuous improvement, modernization, and compliance efforts throughout DHS. Currently, there is no DHS-wide business process management program or software to actively manage the agency's increasingly complex business processes. Additionally, the current staff compliment is increasingly overtaxed as the internal demand for assistance improving processes grows. The additional resources for continuous improvement would be used to:

- Purchase enterprise software to document, store, update, and manage agency-wide business processes
- Purchase professional/technical services for improved business process management expertise and support
- Hire nine new FTEs to assist business areas within the agency manage complex organizational development projects. These projects would include program and process simplification, developing and implementing new processes, reducing waste, identifying and mitigating risk, training DHS staff to use continuous improvement methodologies in their daily work, and advise decision-makers.
- For example, if funding, the additional capacity these FTE provide will allow the Office of Continuous Improvement (OCI) to expand and accelerate their support for grant making processes and grant oversight expansion work across the agency.
- Additionally, the expanded capacity would enable the OCI to support the Office of the Inspector General's SNAP Compliance Project. This critical project will conduct a comprehensive and collaborative two-year process to assess, refine, and potentially re-design fraud prevention, detection, and investigation efforts, utilizing approaches such as Lean Six Sigma, Results-Based Accountability, continuous improvement, and/or appreciative inquiry to reach milestones and goals. The result wil be a recipient fraud prevention, detection, and control framework operating under an agreed upon governance model that recognizes the value and important role of all the stakeholders; defines, distinguishes, and clarifies roles and responsibilities; and ensures consistent interpretation and application of policies, procedures, and processes.

Strengthening Contract Compliance and Grants Oversight (14.0 FTEs)

Contracts and Legal Compliance:

In FY 2021, DHS spent approximately $2.2 billion through grant and Professional/Technical (P/T) contracts. Over the past several years, the amount of spending through contracts has steadily increased, pushing the capacity of attorneys and contract coordinators to keep up with the volume. The pressure to manage an increased volume of contracts in a timely manner without increased staff, increases the risk of mistakes.

- This proposal requests two contract coordinators, one contract attorney, and a paralegal to address the rapidly increasing contract volume and spend.

In addition, DHS' Contracts division is staffed to support the development of requests for proposals (RFPs) and contracts, but not to provide oversight of contract/grants compliance. The complexity of contract matters has increased over the years with varying federal and state contract processes and forms, multiple funding sources, new funding types, and increased federal and state oversight requirements. Providing program areas with oversight and support to ensure compliance with federal and state contract requirements, particularly related to grants contracts, remains a functional gap in the DHS organizational structure.

- This proposal requests ten new positions to establish this centralized function to effectively provide contract compliance, grants oversight, training, guidance, and monitoring across the agency.
- The ten new positions include two managers to oversee the development of a new Centralized Grants Management Office, one technical lead for the Contracts Integration System, and seven grants evaluation specialists to guide and provide grants oversight – three to support Behavioral Health and Hard of Hearing Services, one to support Aging and Disability Services, two to support Children and Family Services, and one to support Operations.

Strengthening Financial Operations (10.0 FTEs)

DHS has an annual budget of over $22 billion and there are many fiscal functions that support the work of the agency. How these functions are carried out is critical to the Department's ability to deliver services effectively, comply with state and federal laws, and be a trusted steward of taxpayer dollars. Maintaining adequate financial controls is critical as the size and complexity of the agency budget has increased and the way work is performed has changed.

Investments in Procurement: The Procurement Division facilitates over $650 million in spending and manages over $500 million in state assets. The division currently has a team of 12 people, incuding one supervisor. A lasting impact of the pandemic is a permanent shift to a remote/hybrid work model for many DHS employees, which has increased the volume of purchasing, changed the way orders are processed, and forced a complete re-engineering of how state assets are managed, accounted for and tracked. With more DHS assets located off site in remote locations, maintaining and tracking physical inventories has become more complicated. Additional capacity is needed to effectively manage our resources and mitigate risk. Additional resources are needed to review and monitor the increased volume of electronic payments. DHS currently has only the cumulative of 1.5 FTE to manage over 800 purchasing cards that are used for 50,000 transactions across the Department.

- This proposal adds one additional supervisor position, which will allow the current supervisor to assume a management role. This role is needed to focus solely on compliance-related procedural and process changes for DHS that align with a work environment that expands beyond the footprint of the physical DHS facilities
- One FTE is requested to keep up with the increased volume of purchasing, including the increased use of purchasing cards, and assist in adapting to changes in procurement when supporting a remote workforce while maintaining compliant and effective control.

Financial Operations: The Financial Operations Division (FOD) is responsible for agency-wide financial processes and compliance with many federal and state financial requirements. The work of FOD is critical to preventing payment errors, detecting and correcting other financial problems that could result in audit findings, ensuring compliance with state and federal grant requirements, and accurately reporting federal financial data to draw down federal funds for human services programs as well as to support our county and Tribal partners. Since FY 2018, the size of the annual DHS budget overseen by FOD has grown 30 percent to $22 billion. In addition, FOD is expected to address continually changing and increasingly complex federal, state, and agency requirements, as well as increased scrutiny over how our work is conducted. Yet, FOD's staffing level has actually decreased over time. This proposal requests resources to enable FOD to continue to meet the financial and compliance challenges that face the human services system in the state.

As result of reduced staffing levels, FOD conducted fewer compliance reviews. In addition, reviews, which are meant to proactively identify and prevent errors in core service areas, are less comprehensive than they were in the past. The result is an increased risk for payment errors and failure to comply with state and federal financial requirements.

- This proposal adds three FTEs to FOD to restore the capacity to conduct thorough, high quality compliance reviews that include root cause analyses and feedback loops to prevent errors from reoccurring in the future.

Programmatic divisions within DHS, as well as external partners such as grantees, counties, and tribes, are highly dependent on FOD for technical assistance and training to conduct financial functions necessary to operate the human services delivery system in Minnesota. Lack of staffing capacity and necessary skillsets prevent FOD from fully supporting our partners' understanding of how to fulfill compliance requirements and access financial data to make informed decisions.

- To avoid future audit findings and mitigate risks, this proposal adds one process control specialist who will document financial processes, identify risk areas, and develop risk mitigation plans.
- To more quickly resolve audit findings and implement process improvements, this proposal adds one project manager who will lead, track, and implement improvement projects and risk mitigation plans.
- To increase awareness of financial compliance requirements and financial processes, this proposal adds two technical assistance and training experts; one to focus on internal DHS end users and one to serve county and tribal partners.
- To enhance the availability and legibility of financial data, more accurately report financial information, and inform better decision making, this proposal adds one technical data analyst.

Simplifying and Strengthening the Grant Making Process for our Partners

This proposal also provides administrative resources to make changes in the grant-making process to allow for better, quicker distribution of funds to smaller entities and culturally specific organizations. This proposal funds a central grants office that would 1) utilize a deliverable-based approach to contracts; 2) implement version control utilizing a Contracts Integration System (CIS); and 3) create an external-facing RFP system and process for interaction wtih grantees.

This proposal includes a team of five staff to implement a central grants office: two Management Analyst 4 (15L) positions for systems development; two Human Services Consultant (17L) positions to provide training, technical assistance, and guidance for grant management; and a manager (HS Manager 1 – 15M) to lead the team. This proposal also includes $202,640 in fiscal year 2024, $308,400 in fiscal year 2025 and $344,400 each year ongoing to fund the development and implementation of the Contracts Integration System improvements.

The grants office will utlize a deliverable-based approach in contracts. They will design contracts to reflect deliverables (outcome-based) contracts instead of budget line items and increase efficiency in both the drafting of contracts and processing of invoices. This approach will help streamline and standardize the approach for developing budgets in contracts. After the execution of the contract, it will reduce the amount of time to review and approve invoices/requests for reimbursements.

The grants office will also implement version control and contract automation in the Contracts Integration System (CIS). This would allow for tracking and managing changes to an RFP and ensure contract documents are automated and electronic. This proposal will subtract the number of steps required, resulting in a time reduction of approximately 30-40% for drafting RFPs and contracts/grants.

Lastly, the grants office will create an external-facing RFP system and process for interaction with grantees. An external-facing RFP web-based system will reduce the number of steps internally and externally. This new system will help streamline grantees' submission process and improve the overall time it takes to submit information to DHS. It will also allow DHS to receive and review responses in a streamlined manner subtracting the number of steps in the overall review process.

Fiscal Impact:

Net fiscal impact on the general fund is $6.2 million in FY 2024-25, and $8.3 million in FY 2026-27. These resources will be used to expand DHS' administrative capacity in the areas of continuous improvement, legal and contract compliance, and financial operations oversight.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impact on Children and Families:

The additional support for the continuous improvement, compliance, and financial management functions will bolster the support received by programs directly impacting children and families. This includes process improvement, project support, increased compliance and audit support, and improved financial services.

Equity and Inclusion:

Increased capacity for continuous improvement, compliance, and financial management functions at DHS will improve the state's ability to oversee important services and programs for some of Minnesota's most vulnerable residents. These changes will benefit all Minnesotans and help ensure that seniors, people with disabilities, children and many others meet their basic needs and have the opportunity to reach their full potential.

Results:

The resources requested in the proposal will improve the legal and contract compliance, procurement, financial management and oversight, and internal audits functions of DHS on an agency-wide level. It will also allow the department to expand its continuous improvement efforts during a time of critical business improvement needs.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			2,046	4,108	6,152	4,126	4,126	8,252
HCAF								
Federal TANF								
Other Fund								
Total All Funds			2,046	4,108	6,154	4,126	4,126	8,252
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	Operations Administration (21,38,38,38)	2,761	5,814	8,575	5,814	5,814	11,628
GF	11	Business Process Management	100	0	100	0	0	0
GF	11	Systems (50% federal match)	101	154	255	172	172	344
GF	Rev1	Admin FFP @ 32%	-916	-1,860	-2,776	-1,860	-1,860	-3,720
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	OPS Administration	21	38		38	38	

Change Item Title: Provider Licensing and Reporting Hub

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	11,084	5,249	4,828	4,165
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	11,084	5,249	4,828	4,165
FTEs	**44.5**	**40.5**	**40.5**	**33.5**

Recommendation:

The Governor recommends investing $16.3 million in FY 2024-25 and $9 million in FY 2026-27 from the general fund for a Provider Licensing and Reporting Hub that will create a unified licensing experience for all human services licensed programs. The funds will be used to implement the Hub for provider licensing and reporting across all license types as well as support ongoing maintenance and operations costs.

This recommendation includes a DHS/MNIT product team, OIG licensing support, training and communications teams, an implementation vendor, Salesforce licensing costs, product maintenance and operations, and contributes to an enterprise Master Data Management (MDM) solution and planning to architect an enterprise Single Sign On (SSO) experience. This planning will allow for the creation and unification of all licensed program-facing functions, including licensing, reporting, enrollment, and billing.

The funds requested reflect a 25% State match in non-salary costs to leverage federal funding for the implementation of the Provider Licensing and Reporting Hub to all licensed programs providing Medicaid and Title IV-E services.

Rationale/Background:

The Department of Human Services (DHS) received an allocation of American Rescue Plan Act (ARPA) funds in FY 2022 for child care information technology and system improvements. In October 2022, DHS began implementing an electronic system on the Salesforce software platform for the licensing and registration of licensed and certified child care programs in Minnesota. The system includes several modular components including a license application and maintenance module, provider reporting module, and CCAP provider registration module. This proposal is to provide funding to sustain ongoing maintenance and operations for the child care functionality and expand the hub to all human services license types at both State and county levels, establishing a unified Provider Licensing and Reporting Hub.

There are approximately 23,000 licensed human services programs across Minnesota who provide critical services to adults and children through 27 license types, including 24 Medicaid and/or Title IV-E license types that provide home and community based services, mental health and substance use disorder services, children's residential facilities, adult day care, and foster care, among others. These programs serve the approximately 300,000 Minnesotans who receive services, and indirectly serve many more as family of persons who receive services.

The systems and processes for the licensing of human services programs both at DHS and county agencies are largely paper-driven through documents only available in English. Information and data are collected on paper documents that are exchanged via postal mail. Licensed programs are disadvantaged by the existing paper processes and systems, which occupy an unnecessary amount of the program's time and resources at a detriment to the communities and persons served. These processes also create unnecessary administrative burden for DHS and county agencies, as they rely on manual data entry into multiple different aging legacy systems, and in some cases, data on paper is not captured electronically. This results in incomplete data and limits the ability for DHS and county agencies to make informed data-driven decisions and share data among agencies and with internal and external stakeholders. Incomplete data and a lack of efficient data sharing between legacy systems also limits the ability for DHS and counties to efficiently oversee licensed programs and creates opportunity for program integrity concerns and exploitation by bad actors.

This proposal will remove barriers, alleviate pain points, and expedite licensing processes for human services programs, allowing for more time and resources to be dedicated to the populations they serve. The Provider Licensing and Reporting Hub will create a single, unified experience for licensed programs with multiple language support to replace current paper-based processes. Licensed programs will have self-service online access to their license information in their native language with an increased transparency of licensing processes. A unified Hub will allow for stronger collaboration and data sharing between DHS and county agencies, providing better insight into licensed programs and easier identification of program integrity red flags. Administrative burdens will be reduced, allowing for reallocation of resources currently expended to support existing paper processes and disparate aging legacy systems at both state and county levels. This proposal will also increase transparency and centralize provider compliance monitoring, health and safety information, and public benefit program participation information into one place on an enhanced public website. Licensed programs will also be able to advertise service openings on the public website, helping persons receiving services, family members, and the general public to conveniently find the services they need.

Salesforce Software Platform

The Provider Licensing and Reporting Hub will be configured on Salesforce software currently used for the child care licensing hub. Salesforce is a cloud-based customer relationship management software used widely in both the private and public sectors to meet the needs of customers and deliver services more efficiently. Salesforce is used in 42 states for government human services applications such as Medicaid, child support, human services licensing, and Minnesota's own COVID-19 contact tracing system. Salesforce is a Software as a Service (SaaS), cloud-based product where the software and associated hardware costs are paid for through an annual software licensing cost. SaaS, including Salesforce, is adaptable, configurable, and scalable, allowing for rapid implementation of new systems and products. The anticipated time to delivery for the Provider Licensing and Reporting Hub is approximately 12 months, significantly shorter than delivery timelines for custom built software products. This will allow DHS and counties to quickly meet the needs of licensed programs and the Minnesotans they serve.

Product Transformation

The Provider Licensing and Provider Reporting Hub will be accomplished through a product approach as part of the Project to Product Transformation initiative from MNIT@DHS. The Project to Product Transformation will implement new ways of thinking about our work centering around the people and clients we serve to deliver better value for our customers and services for the people of Minnesota. Shifting to a product model involves moving from temporary project teams to persistent, cross-functional product teams that own specific business capabilities, customer experiences, or product areas. The product approach is focused on the needs of the customer and uses human-centered design to collaboratively create experiences and products that are not only designed with the customer in mind, but with customers' direct feedback and input. The product approach allows for rapid delivery of value to customers and is inherently flexible and responsive to make adjustments as needed. Federal funding guidance now incorporates language supporting product transformation and recommendations from state advisors, including the IT-Blue Ribbon Council, are encouraging a move in this direction.

Integrated Service Delivery (ISD) and the DHS Strategic Plan
The Modernization Strategic Plan, a collaborative effort between counties, Tribal Nations, DHS, and MNIT@DHS, identified Integrated Service Delivery (ISD) as the mechanism to ensure that all Minnesotans, from the people who access services to the workers who assist them, will have access to a full range of integrated, person-centered human services that are supported by comprehensive, sustainable technology. This proposal furthers the ISD initiative and is a step toward realizing Integrated Service Delivery. The following values of ISD directly align with the Provider Licensing Reporting Hub:

- Approachable new ways to access human services programs
- Efficient data collection process with intuitive features
- Uniform data security and privacy standards, and secure data collection and access
- Proactive approach that supports continuous improvement at all levels
- Services of all types — from in-person to online — delivered in a flexible, comprehensive system that supports individual needs and goals.
- Personalized access for users and community/service partners, including 24/7 online information, and ways to take action through an online account

The DHS Strategic Plan outlines the Department's focused efforts and connects DHS work to the Governor's One Minnesota Plan, which aims to improve the lives of all Minnesotans. The One Minnesota Plan articulates a common mission, vision, guiding principles and priorities that align the collaborative work of state agencies. Several strategies and goals from the 2020-2022 DHS Strategic Plan are reflected in this proposal and directly contribute to the Governor's priorities:

- *DHS Strategic Key Initiative: Our Stand—Better health, fuller life and lower cost for Minnesotans working to achieve their highest potential.*
  Goal 2: Reduce disparities and make access to services easy.
  Strategy B: Move toward an integrated human services delivery system that includes a plan for data management and technology platforms to create positive, consistent and equitable experiences with DHS.
  One MN: Equity and Inclusion, One MN: Fiscal Accountability and Measurable Results
- *DHS Strategic Key Initiative: Operational Excellence—National ranking as a well-run state agency.*
  Goal 3: Improve the delivery of technology across the human services system.
  Strategy A: Improve the timeliness, quality, sustainability and security of IT systems at DHS and for the people we support. One MN: Fiscal Accountability and Measurable Results

Development of the 2023-2026 DHS Strategic Plan is underway. The DHS Senior Strategy Team has identified several priorities to achieve DHS's biggest possibilities, based on input from DHS staff, partners, and the community. This proposal addresses the following priorities:

- Improve DHS's capacity as a flexible, agile, responsive customer service organization
- Advance technology and processes to create a seamless state-funded, county- and tribal-administered human services system.
- Become known for developing robust approaches to co-creating work

Proposal:

This proposal establishes an integrated Provider Licensing and Provider Hub for human services licensing, with robust functionality for internal and external users to be used by state and county agencies. Areas of overlap between processes will be streamlined to improve efficiency, reduce administrative burdens, and reduce the amount of time and resources that human service programs spend on applying for and maintaining a license. Licensed programs will experience a consistent and cohesive licensing, certification, and subsidy registration process whether it is occurring at DHS or in any of Minnesota's 87 counties. Information about human services licensing, licensing processes, and training will be available to licensed providers and the general public in multiple languages, including Spanish, Somali, and Hmong.

To accomplish this, a permanent cross functional product team comprised of DHS and MN.IT staff will be established to expand the implementation of the Provider Licensing and Reporting Hub to all human services license types. This persistent, cross-functional product team will provide ongoing maintenance, operations, and oversight for the Provider Licensing and Reporting Hub using agile methods to meet the needs of our customers and users. To deliver value more quickly, an implementation vendor will be hired to configure the Salesforce product and implement the Provider Licensing and Reporting Hub for all DHS licensed providers. To assist providers with the transition from an entirely paper-based process to electronic process, funding will also support staff dedicated to provider support, communications, and training. The positions in this proposal include:

Product Team			
Agency, Position, and Classification	**FTE Count**	**Permanent or Temporary**	**Position Purpose**
DHS-OIG, Product Manager, Human Services Manager 1 (15M)	1	Permanent	Oversees all aspects of product, develops and ensures execution of "big picture" and vision of product, long-term management of product including product sustainability and product advancement. Ensures all components meet the overall vision and are functioning cohesively. Coordinates between administrations and divisions. Supervises and develops direct reports.
DHS-OIG, Product Owner: Licensing Operations (Human Services Program Consultant) (17L)	1	Permanent	Develops and executes operational vision and implementation of licensing operational functionality business line in alignment with product vision and roadmap. Oversees operational implementations and coordinates with all licensing units to maximize release potential. Represents the voice of internal and county users/customers.
DHS-OIG, Product Owner: Provider Experience (Human Services Program Consultant) (17L)	1	Permanent	Develops and executes licensing provider user experience vision. Coordinates between business area representatives for product provider facing decisions. Facilitates meetings for discussion and, ultimately, consensus between business areas while championing and advocating for the overall provider experience business line.
DHS-CFS, Product Owner: CCAP Provider Registration and Wayfinder (Human Services Program Consultant) (17L)	1	Permanent	Develops and executes CCAP provider registration and WayFinder user experience business line vision. Coordinates between business area representatives for product decisions. Facilitates meetings for discussion and, ultimately, consensus between business areas while championing the needs of CCAP Providers and WayFinder user business line.
DHS-DSD: Product Owner: BIRF and HCBS Provider Reporting (Human Services Program Consultant) (17L)	1	Permanent	Develops and executes Behavioral Incident Reporting Form and other HCBS forms user experience vision. Coordinates between business area representatives for product decisions. Facilitates meetings for discussion and, ultimately, consensus between business areas while championing the needs of the HCBS provider reporting business line.

Product Team			
Agency, Position, and Classification	**FTE Count**	**Permanent or Temporary**	**Position Purpose**
HCBS/ADC Stakeholder Engagement Specialist (Human Service Program Representative 2) (14L)	1	Temporary	Develops stakeholder engagement strategy for HCBS and ADC providers in consultation with Product Manager, coordinates and executes stakeholder engagement activities. Works closely with the Provider Product Owner to ensure HCBS user needs are met.
MH/SUD/CRF Stakeholder Engagement Specialist (Human Service Program Representative 2) (14L)	1	Temporary	Develops stakeholder engagement strategy for MH/SUD/CRF providers in consultation with Product Manager, coordinates and executes stakeholder engagement activities. Works closely with the Provider Product Owner to ensure MH/SUD/CRF provider needs are met.
Foster Care Stakeholder Engagement Specialist (Human Service Program Representative 2) (14L)	1	Temporary	Develops stakeholder engagement strategy for Foster Care providers in consultation with Product Manager, coordinates and executes stakeholder engagement activities. Works closely with the Provider Product Owner to ensure Foster Care provider needs are met.
MN.IT: Scrum Master (ITS4) (17L)	1	Permanent	Lead the scrum team in using Agile methodology and scrum practices. Help the product owner and development team to achieve customer satisfaction. Remove impediments and coach the scrum team on removing impediments. Help the scrum and development teams to identify and fill in blanks in the Agile framework. Resolve conflicts and issues that occur. Help the scrum team achieve higher levels of scrum maturity. Support the product owner and provide education where needed.
MN.IT: Data and Integration Architect (21L)	1	Permanent	Plans, guides, and leads the system architecture design to maintain architectural integrity. Leverage existing Component Library for reusability. Guides the development of the enterprise data model ensuring data integrity is maintained. Consults with project data leads on any issues/decisions related to data or integration model.
MN.IT: Lead Salesforce Developer (ITS5) (19L)	1	Permanent	Development of the Salesforce application or enhancements through configuration and if required through Apex or Visualforce. Performs technical analysis, design, configuration, and implementation support for system integrations and Salesforce customizations. Develops custom applications and code (Visualforce, Components, Apex Controller, Trigger, Callouts). Writes, tests, analyzes, and implements high quality code according to specifications. Manages the development team and leads Solution design,

Product Team			
Agency, Position, and Classification	**FTE Count**	**Permanent or Temporary**	**Position Purpose**
MN.IT: Salesforce Full Stack Engineers (ITS4) (17L)	4	Permanent	Defines high-level component for the solution. Leads the estimation of development efforts for user stories, and runs the Iteration. Planning and Review workshops. Evaluates Out-Of-The-Box options or design patterns that require minimal customization. Defines & oversee standard and practices, including Build /Buy Configure Strategy. Performs code reviews and makes sure development team is following standards Ensures proper Test Coverage and Unit Testing is performed. Leverages AppExchange for public reusable components. Coordinates deployments with Release Manager
MN.IT: Salesforce System Administrators and Help Desk (ITS3) (14L)	7	Permanent	Develop business user stories with the Product Owner. Responsible for business, data, reporting and testing requirements gathering; workflow analysis, user stories, and acceptance criteria. Develops test scenarios for UAT testing. Gather, create and document current and future business process flows. Performs Functional Testing and oversees User Acceptance Testing. Executes: User Record Management, New Fields, Page Layouts & Objects, Report Type Creation & Report & Dashboard Folders, Workflow, Assignment & Validation Rules, Process Builder / Visual Flow Email & Mail Merge Templates, List Views, Home Page Announcement. Manages all new user set-ups and deactivation, including transferring ownership of accounts/contacts/opportunities for deactivated users. Performs new release evaluations and assess impact. Creates ad-hoc reports to meet business requirements. Provides Technical Support to resolve configuration defects.
MN.IT: Azure Data Lake Developer (ITS5) (19L)	1.5	Permanent	Support replication of data created in Salesforce into DHS Azure Data Lake. Support data and analytics team to develop data lake in accordance with best practices.
MN.IT: FileNet Developer (ITS5) (19L)	1	Temporary	Lead development of FileNet interface. Create new document classes, document types. Implement records management.
MN.IT: Security Architect (ITS5) (19L)	1	Temporary	Ensures that business use of Salesforce is compliant with all compliance, information security, legal and data privacy standards and MN.IT enterprise security requirements are met.
MN.IT: Enterprise Data and Integration Architect	1	Temporary	Coordinate MN.IT resources to support the implementation vendor and provide strategic support to ensure vendor success. Plans, guides, and leads the system architecture design to maintain architectural integrity. Leverage existing Component Library for reusability. Guides the development of the enterprise

Product Team			
Agency, Position, and Classification	**FTE Count**	**Permanent or Temporary**	**Position Purpose**
			data model ensuring data integrity is maintained. Consults with project data leads on any issues/decisions related to data or integration model.
MN.IT: Quality Assurance Integration Testing Analyst (ITS5) (19L)	1	Temporary	Performs Functional Testing of all integrations with the Salesforce product in line with Enterprise Integration Strategy.

Provider Support Team			
Agency, Position, and Classification	**FTE Count**	**Permanent or Temporary**	**Position Purpose**
DHS-OIG: Operations Manager (Human Services Manager 2)	1	Permanent	Oversees the functions of the Provider Support Unit, Communications and Training Team, and Licensing Operations Team.
DHS-OIG: Provider Support Center Supervisor (Human Services Supervisor 3) (21K)	1	Permanent	Oversees the day-to-day functions of the Provider Support unit which provides technical assistance to licensed providers in navigating and enrolling in the Provider Hub Salesforce licensing system. Ensure a high level of customer service is provided to end-users of the system. Coordinate with MN.IT and implementation vendor staff to address defects or additional improvements to the system based on reports from providers and support center staff.
DHS-OIG: Provider Support Center Representative Lead (Human Svcs Prog Spec 2) (8L)	1	Permanent	Maintain efficiencies, continuity and coverage of customer service to licensed providers. Handle escalated communications and provide guidance to support center representatives for complex technical issues. Interface with MN.it and implementation vendor staff to rectify reports of system issues, defects, or implement suggestions for improvements.
DHS-OIG: Provider Support Center Representative Lead (Human Svcs Prog Spec 2) (8L)	1	Temporary	For one year, maintain efficiencies, continuity and coverage of customer service to licensed providers. Handle escalated communications and provide guidance to support center representatives for complex technical issues. Interface with MN.it and implementation vendor staff to rectify reports of system issues, defects, or implement suggestions for improvements.
DHS-OIG: Provider Support Center	6	Permanent	Provide first-level technical assistance to licensed providers in utilizing the Provider Hub system. Customer

Provider Support Team			
Agency, Position, and Classification	**FTE Count**	**Permanent or Temporary**	**Position Purpose**
Representative (Human Svcs Prog Spec 1) (5L)			service assistance will be provided via phone, chat and email in real-time to ensure positive user experiences.
DHS-OIG: Provider Support Center Representative (Human Svcs Prog Spec 1) (5L)	2	Temporary	For one year, provide first-level technical assistance to licensed providers in utilizing the Provider Hub system. Customer service assistance will be provided via phone, chat and email in real-time to ensure positive user experiences.

Communications and Training Team			
Agency, Position, and Classification	**FTE Count**	**Permanent or Temporary**	**Position Purpose**
DHS-OIG: Communications and Training Supervisor (Human Services Supervisor 3) (21K)	1	Permanent	Oversees the day-to-day functions of the Communications and training unit to develop and implement training materials for licensed providers and division staff to utilize and navigate the Provider Hub Salesforce system. Provide hands on training for internal users and virtual and recorded trainings for end users as is necessary for user proficiency. Work with Salesforce and implementation vendor to customize trainings to meet the needs of the division and licensed providers.
DHS-OIG: Digitial Content Specialist (Information Officer 3) (10L)	1	Permanent	Work with System Modernization specialists to ensure all web content surrounding the implementation of the Provider Hub Salesforce system is up to date, appropriately branded and accessible. Work with Salesforce and implementation vendor to update and maintain the Provider Hub login page and to ensure that all content is ADA compliant and accessible. Work with Training specialists to develop appropriate training forms that are accessible and manage internal and external training web sites.
DHS-OIG: Digitial Content Specialist (Information Officer 3) (10L)	1	Temporary	For one year, work with System Modernization specialists and Information Officer 3 to ensure all web content surrounding the implementation of the Provider Hub Salesforce system is up to date, appropriately branded and accessible. Work with Salesforce and vendor to update and maintain the Provider Hub login page and to ensure that all content is ADA compliant and accessible. Work with Training specialists to develop appropriate

Communications and Training Team			
Agency, Position, and Classification	**FTE Count**	**Permanent or Temporary**	**Position Purpose**
			training forms that are accessible and manage internal and external training web sites.
DHS-OIG: Lead Training Coordinator (Human Services Program Consultant) (17L)	1	Permanent	Provide overall direction for the development and implementation of training materials for licensed providers and division staff on utilizing and navigating the Provider Hub Salesforce system. Provide hands on training for internal users and virtual and recorded trainings for end users as is necessary for user proficiency. Work with Salesforce and implementation vendor to customize trainings to meet the needs of the division and licensed providers.
DHS-OIG: Training Assistant (Human Services Program Representative 2) (14L)	1	Permanent	Assist training coordinator in the development of all training materials related to the Provider Hub Salesforce system. Provide training to users of the system as directed by the Training Coordinator and maintain all training records and rosters.

This proposal will also clarify requirements for providers and counties to use the provider hub for provider applications, changes, maltreatment reports, requests for reconsideration, and appeal of licensing actions. This proposal will also provide authority for DHS Commissioner to access tax information from the Minnesota Department of Revenue to verify tax information to improve program integrity and detect patterns of fraud, waste, and abuse.

Additionally, this proposal funds an enterprise Master Data Management (MDM) solution and implementation vendor for all of DHS data and programs. Master data management (MDM) ensures there is a single master record for each person, place, or program across internal and external data sources and applications. A MDM solution will prevent DHS from having inconsistent or duplicate information about the people and programs we serve, creating a consistent, reliable source of truth. Master data serves as a trusted view of critical data that can be managed and shared across DHS to promote accurate reporting, reduce data errors, remove redundancy, and help DHS make data-driven decisions. MDM is a crucial component that is key for Integrated Service Delivery (ISD), as ISD relies on accurately identifying one person or entity across all DHS systems. Moreover, MDM is critical for program integrity and will greatly improve the capacity to detect of fraud, waste, and abuse across DHS' many programs.

Finally, this proposal funds planning to architect an enterprise Single Sign On (SSO) experience. This planning will allow for the creation and unification of all licensed program-facing functions, including licensing, reporting, enrollment, and billing.

Impact on Children and Families:

The Provider Licensing and Reporting Hub will increase transparency and centralize licensed program compliance monitoring, health and safety, as well as public benefit program participation information into one place for consumers and families. The Hub will also allow programs to advertise openings, helping families to find the services they need.

Equity and Inclusion:

Persons who do not speak English will have significantly increased access to resources and information in their native language through multiple language support in the Licensing Hub. This is critical to remove significant barriers for persons who do not speak English to apply for and maintain a human services license. Currently, DHS often receives applications and communications from attorneys or consultants who have been hired to navigate licensing processes on behalf of persons who do not speak English. This presents a barrier and burden to these populations who face an indirect additional cost that native English speakers do not.

Increased transparency, removal of existing barriers, development of user-friendly processes, and 24/7 self-service access to licensing information will empower licensed programs and promote equity across all populations to allow every Minnesotan equal opportunity to access information and apply for or maintain a human services license. Underserved populations who engage with or receive services from human services programs will benefit from increased access to information and compliance data about programs. This proposal will remove barriers, alleviate pain points, and expedite licensing processes for human services programs, allowing for more time and resources to be dedicated to underserved populations.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒ No

Tribal Nations license and administer human services programs independently from DHS and county agencies. Native American families who receive services from human services programs licensed by DHS and county agencies will benefit from this proposal by removing barriers, alleviating pain points, and expediting licensing processes for human services programs, allowing for more time and resources to be dedicated to Native American families receiving services.

Impacts to Counties:

County partners who administer human services licenses have a variety of licensing processes, resulting in a range of experiences for Minnesotans who use, operate, or are applying for a human services licensed program. The experience for residents of one county can vary significantly from the experience of residents in another county. The Provider Licensing and Reporting Hub will simplify and streamline licensing processes to create a consistent and cohesive experience across all of Minnesota's 87 counties, reducing disparities found with unequal processes.

The Provider Licensing and Reporting Hub will impact county partners by automating the exchange of information and data between counties and DHS, replacing the current manual processes that occupy county resources to complete. DHS and county partners will also experience greater and more meaningful collaboration through increased transparency between agencies and more robust data sharing. Finally, counties will be able to rely on state funded systems and may find cost savings by retiring current county funded systems that support these functions.

IT Costs:

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll						
Professional/Technical Contracts	28,351,000	5,351,000	4,121,000	4,121,000	4,121,000	4,121,000
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services	1,000,000	500,000	500,000	500,000	500,000	500,000
Staff costs (MNIT or agency)	5,946,952	6,376,684	6,376,684	5,214,816	5,214,816	5,214,816
Total	**35,315,952**	**12,227,684**	**10,997,684**	**9,835,816**	**9,835,816**	**9,835,816**
MNIT FTEs	19.5	19.5	19.5	19.5	19.5	19.5
Agency FTEs	25	21	21	18	18	18

NOTE: IT costs included in the table above do not include FFP offset.

Results:

Performance will be measured through the following outcomes:

- Implement a unified Provider Licensing and Reporting Hub for the licensing of all human services programs at both State and county agencies.
- Remove language barriers for Minnesotans who do not speak English.
- Reduce the amount of time to obtain a human services license.
- Increase satisfaction with licensing processes.
- Reduce the administrative burden on human services programs, DHS, and county agencies, resulting in rapid service delivery.
- Improve program integrity and ability to identify program integrity concerns.
- Increase in the number of licensed human services programs.
- Increase in the amount and quality of data collected.
- Improve the ability for DHS and county agencies to make decisions with reliable and comprehensive data.

Performance data will be collected through data and metrics in the Provider Licensing and Reporting Hub, as well as feedback from licensed human services programs.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			11,084	5,249	16,333	4,828	4,165	8,993
HCAF								
Federal TANF								
Other Fund								
Total All Funds			11,084	5,249	16,333	4,828	4,165	8,993
Fund	**BACT #**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	DHS Product Team FTEs (8,8,8,5)	1,114	1,296	2,410	1,296	837	2,133
GF	11	OIG-Licensing Operations and Support FTEs (17,13,13,13)	2,094	1,866	3,960	1,866	1,866	3,732
GF	11	MNIT Enterprise Services FTEs (19.5,19.5,19.5,15.5)	1,378	1,607	2,985	1,607	1,256	2,863
GF	11	Department of Revenue Data Exchange Interagency Agreement	275	227	502	60	60	120
GF	11	Implementer Resources (Salesforce implementer P/T, project management)	3,563	0	3,563	0	0	0
GF	11	Annual Licensing Costs (Salesforce, S-Docs, Smarty Streets, DocuSign)	755	755	1,510	755	755	1,510
GF	11	FileNet Connector for Salesforce	250	125	375	125	125	250
GF	11	Azure Data Lake	520	458	978	150	150	300
GF	11	Master Data Management Solution (COTS, vendors, staff, training)	1,500	0	1,500	0	0	0
GF	11	Single Sign-on Provider Hub Experience Planning	750	0	750	0	0	0
GF	REV1	Admin FFP (DHS) @ 32%	(1,115)	(1,085)	(2,200)	(1,031)	(884)	(1,915)
		Requested FTE's						
Fund	**BACT #**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
		DHS FTEs	25	21		21	18	
		MNIT FTEs	19.5	19.5		19.5	15.5	

Statutory Change(s):

Minnesota Statutes, section 245A.04
Minnesota Statutes, section 270B.14

Change Item Title: Background Studies Operations

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	1,206	1,794	2,000	2,000
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	**1,206**	**1,794**	**2,000**	**2,000**
FTEs	**17.0**	**17.0**	**19.0**	**19.0**

Recommendation:

The Governor recommends investing $1.2 million in FY 2024, $1.8 million in FY 2025, and $2,000,000 in FY 2026 and each year thereafter for the Department of Human Services (DHS) Background Studies Division (BGS) to fund critical background studies positions that support Minnesota's workforce needs and the safety of children and vulnerable adults.

The Background Studies Division (BGS) in the Office of Inspector General is statutorily responsible for performing many complex functions within a highly regulated industry while also operating as a fee-for-service enterprise. The volume of background studies submitted into DHS' statewide background study system has increased significantly while staffing has failed to keep pace with this growth and the demand for timely determination responses. Of equal importance, background study compliance requirements and the state and federal laws for over 70 distinct provider types have increased in complexity. This proposal will increase the DHS background study system's effectiveness and efficiency while improving stakeholder satisfaction.

Rationale/Background:

The requested resources in this proposal are critical for the DHS Background Studies Division to carry out its mission to ensure compliance, program integrity, and quality assurance, and to assure the health and safety of vulnerable children and adults.

DHS' statewide background study system has experienced a higher degree of complexity, substantial growth, and increased volume of activities in the following areas:

- Background Studies Division and related Legal operations
- NETStudy 2.0 System
- Contracted Fingerprint and Photo Services Vendor
- Enhanced studies - federally funded program requirements
- Bureau of Criminal Apprehension (BCA) and Federal Bureau of Investigation (FBI) audits
- Increased complexity of background study requirements

Critical and essential background study functions are being performed without a corresponding infrastructure capable of ensuring DHS' statutory obligations are met. The insufficiency in infrastructure and staffing capacity negatively impacts the department's timely completion of background studies, delays background study determinations, creates a sizeable backlog of studies, exposes risks related to quality assurance and quality controls, hampers stakeholder engagement, and ultimately impedes the provider's ability to respond to their

evolving workforce needs and provision of services to the state's most vulnerable populations. This proposal reflects an important first step in mitigating these risks and improving service delivery.

The volume of completed background studies determinations and providers required to submit background studies has dramatically increased each year—from 227,403 determinations completed in FY2018, to 370,097, in FY2022. At present, 70+ provider types, including more than 35,000 active providers, are required to submit background studies. This results in a high degree of complexity in reviewing criminal history records information on individual study subjects and making fitness determinations for eligibility, increases in appeals and litigation, increased demands for provider engagement, a growing number of inquiries received by the background studies contact center, and continued enhancements of the NETStudy 2.0 background studies system. These numbers continued to increase while the division's staffing complement remained relatively unchanged.

Sustainability of DHS' background study processes, and the department's ability to meet the growth and demands inherent in the work performed, requires that DHS address current structural deficits and fund critical background studies positions to support Minnesota's workforce needs and the safety of children and vulnerable adults.

Proposal:

This proposal would add staff capacity, strengthen the operational infrastructure of the Background Studies Division and related Legal Division, ensure the ability to perform and provide critical functions, and improve engagement and support to all providers required to submit background studies in accordance with Minnesota Statutes, Chapter 245C.

Contact Center

Additional funding in this proposal increases the staffing complement in the BGS Contact Center adding 6.0 FTE. This funding will support incremental improvements in contact center operations, including:

- Decreased average wait/hold times of incoming callers and overall response times needed to communicate with providers and individual study subjects to answer questions related to eligibility determinations, study statuses, and reconsiderations and appeals processes;
- Improved capacity of triage functions to process studies that can quickly be cleared when there is no need for additional staff record reviews;
- Increased staff time to communicate with providers, assisting in their understanding of background study statuses, disqualifications, and appeals/reconsideration processes; and
- Greater staff capacity to respond to email inquiries through the new customer relationship management (CRM) – Dynamics 365 software.

The Contact Center is the division's direct customer support for study subjects, entities, counties, other state agencies, and the public. Primary functions of the Contact Center are: answering inbound calls, performing triage for all incoming studies, and managing the CRM application for all email inquiries received. They answer approximately 700-1,000 calls per week and an equal amount (if not more) of emails. Contact Center staff explain the complexities of a myriad of background study, fingerprinting, and appeals processes in concise and understandable terms while answering questions and providing technical assistance. This unit is responsible for expediting study completion, assigning studies to researchers or research support staff in other units for further review.

Research Team

This proposal establishes a new research team, adding 5.0 FTE to help meet the increased workload attributed to the continuous growth in complexity, requirements, and the increased number of providers required to submit background studies. Adding an additional research team will result in improved supervisory oversight and incremental improvements in alleviating backlogs of background studies as higher volumes of studies are received. These positions:

- Determine fitness eligibility of study subjects

- Take action (e.g. ordering supervision; or obligation to remove, issuing determination notices)
- Assess risk of harm
- Request records from other jurisdictions
- Review criminal history records information received

Research units conduct timely investigative exploration for each background study subject's records. These records may include maiden names, aliases, multiple addresses, length of employment, court appearances, investigatory interviews, prison and jail sentences, criminal charges, indictments, arrests, convictions, maltreatment findings, etc. Research units also collaborate with OIG legal counsel to clarify records and determine the relevancy of offenses, criminal and maltreatment records, and severity of a study subject's risk of harm.

NETStudy 2.0 Requirements and Testing Team

The proposal adds 2.0 FTE to the NETStudy 2.0 team to support technology system build requirements and testing needs associated with the ongoing development of NETStudy 2.0, the web-based system to submit background study requests to DHS. These positions:

- Coordinate with stakeholders to gather full project requirements and document performance expectations
- Oversee NETStudy 2.0 modifications to assure the changes align with requirements and do not impact existing system functionality
- Develop test cases based on test objectives and conditions derived from project requirements
- Conduct tests of the system or system features prior to implementation

NETStudy 2.0 is used by entities to submit background studies to DHS, by the background studies division to complete submitted studies, and by other divisions for background study enforcement and compliance. Requirements gathering and testing are critical to ensuring the seamless functioning of NETStudy 2.0 as complexity and enhancements are introduced to the system to address demands for new and modified functionality.

Legal Unit

The proposal adds 1.0 FTE to the OIG Chief Legal Counsel office to help meet the increased volume of legal advice and services required by the Background Studies Division. Legal positions:

- Advise the Background Studies Division on policy and compliance matters
- Determine whether certain investigation and court records contain disqualifying information
- Conduct Preponderance of Evidence reviews and translate out of state criminal record information into what is comparable in the Minnesota criminal justice system
- Decide whether to uphold or rescind disqualifications and/or whether to grant set asides or variances on reconsiderations for DHS licensed and unlicensed programs
- Review and advise the Background Studies Division on expungement petitions and orders served on DHS and MDH
- Respond to data requests
- Collaborate with BGS on legislation and contracts
- Serve as in-house counsel with the Attorney General's Office on expungement, disqualification appeals, and related litigation

Data and Analytics Office

This proposal will add 1.0 FTE to the OIG Data and Analytics Office to support the data and analytics needs of the Background Studies Division. The addition of this position will enable to the Data and Analytics office to:

- Develop and implement staff and business metrics to measure the performance of the Background Studies Division and specific business functions within the division

- Use data to identify process improvement opportunities to increase Background Study efficiency and improve the experience of study subjects and providers
- Create operational dashboards to track performance in real time, improve processing times, and decrease wait times for background study subjects and providers
- Improve data collection and support the creation of data systems to measure processes that are not currently in the NETStudy 2.0 system including call center metrics, legal appeals, CANR checks, board checks, maltreatment reviews, statutory comparisons, and records requests
- Support the NETStudy 2.0 requirements and testing team by creating custom reports and reports that identify data system and performance issues
- Support the quality assurance and regulatory compliance team by measuring and implementing benchmarks for functional areas and identifying data quality issues
- Develop public-facing dashboards and reports to increase transparency of processes and performance of the Background Studies Division

This additional staff member will enable the Data and Analytics office to support quality assurance and process improvement initiatives planned in the Background Studies Division, provide insights based on data to make critical business decisions, create metrics that can be viewed in real time to evaluate performance and identify areas for improvement, and support the continued improvement of data systems to measure critical Background Studies processes. This data and analytics support is critical to the success of other initiatives and teams in the Background Studies Division.

Quality Management System

The additional funding in this proposal adds 3.0 FTE to establish a new business unit to focus on quality assurance and quality control standards in the Background Studies Division. This funding will help ensure:

- Implementation of BGS' quality management system, assuring that complex state and federal background study laws and compliance requirements are met
- Evaluation of current internal standards, practices, policies, and procedures
- Establishment of benchmarks for functional areas
- Implementation of regular internal quality assurance reviews, assessments, and monitoring of background study processes and systems, enabling DHS to continue to maintain alignment with state and federal requirements
- Compliance with BCA and FBI requirements related to the handling and dissemination of criminal justice information (CJI) and criminal history records information (CHRI)

The quality assurance regulatory compliance unit would ensure DHS' statewide background study system and technologies operate with consistent practices and meet standards set by internal, state, and federal governing bodies.

Provider Relations and Training

This proposal will add 1.0 FTE to the Integrated Planning, Policy, and Analysis (IPPA) Unit and to the Enterprise Training Team (ETD) within the Background Studies Division at DHS to support improvements in provider relations and training. This funding will:

- Implement a provider relations strategy
- Increase capacity to provide ongoing technical and system training to providers and sensitive information persons authorized to submit background study requests in NETStudy 2.0
- Provide background study overview sessions through webinars, other virtual platforms, and in-person
- Participate and engage with providers, counties, tribal communities, and trade associations regarding DHS' background study system and processes
- Respond to complaints received about services rendered through DHS' statewide contracted fingerprint vendor

With this additional staff member, DHS will be able to better support providers through additional outreach, engagement, consultation, and technical assistance.

Impact on Children and Families:

The proposal protects the health, safety, and rights of those receiving services from DHS and other state agency programs while contributing to the availability of an appropriately vetted workforce for providers serving vulnerable children and adults.

Equity and Inclusion:

There are no anticipated disparities created, nor negative effects for underrepresented individuals or communities in this proposal. We anticipate a significant positive impact to persons receiving background study services as well as for providers who are required to submit background studies. The additional staff capacity should increase regulatory compliance and ensure the health and safety of vulnerable populations. It will also have a positive effect on providers by ensuring more timely responses in completing study determinations, and the ability to emphasize improvements in customer service in our overall ability to be responsive to concerns and complaints.

Background studies activities at DHS supports the provision of quality services to persons with disabilities and older adults of all racial identities, sexual orientations, and gender identities.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

DHS will be better able to support tribes with processing background studies for their licensed programs and meeting compliance requirements. DHS will be able to increase its engagement with tribal communities by providing additional outreach, engagement, consultation, and technical assistance.

Impacts to Counties:

This proposal will have a positive impact for counties. With faster completion times for studies, the financial burden on counties funding foster care services will be greatly reduced because the state will take over funding sooner. With additional staff, DHS will be better able to support counties bringing licensed providers into compliance with background study requirements. DHS will be able to increase its engagement with county agencies by providing additional outreach, consultation, and technical assistance.

Results:

Existing Measures

While developing this proposal, DHS analyzed key metrics addressing the volume of work within the Background Studies Division and performance measures focused on the effectiveness of service delivery:

- To assess the volume of background studies processed, DHS measured the number of background study completed determinations, including initial determinations and rapback. In FY 2022, DHS completed 370,097 determinations compared to 264,140 in FY 2021.
- To assess the impact of service request volume on the level of support provided to study subjects and providers submitting study applications, DHS measured the number of calls and emails received by the contact center. During the week of September 19, 2022, the contact center received 830 calls and 1,097 emails.

The volume of background studies work continues to grow, but the staff complement within the division remains static. Building operational capacity within the division is necessary to support Minnesota's workforce needs.

To further inform this request for additional FTEs, DHS also measured the impact of the increased volume of background studies on the Background Studies Legal unit and the Office of the Inspector General's Data and Analytics Office.

- To assess the impact of background studies volume on the Background Studies Legal unit, DHS measured the number of reconsideration requests for DHS licensed and unlicensed programs (1,549 requests in 2021) preponderance of evidence reviews (523 reviews in 2021), and statutory comparisons (298 cases in 2021).

Proposed New Measures

During and after the implementation of this proposal, DHS will add the following measures to existing metrics to analyze the robustness of the background studies infrastructure and the quality-of-service delivery:

- To assess the overall effectiveness of service delivery, DHS is consulting with Minnesota Management and Budget to develop background study determination progression and performance metrics that will be included each of the major functions in background studies (contact center, record requests, research, NETStudy 2.0, and enterprise training).
- To assess the ongoing development of NETStudy 2.0, DHS will measure the system's capacity to maintain monthly production deployments; to support deeper and more involved testing prior to deployment; to increase the scope of test cases and test scenarios; to increase testing tracking (both scenarios and results); and to increase the percentage of passed test cases.
- To assess customer service, DHS will measure the call center's capacity to increase customer satisfaction; to increase the number of callers that are able to come into the queue (current limit is 30 callers); to reduce the timeframe for email responses; to reduce wait time for callers; and to increase contact center hours.
- To assess the adequacy of self-help available for providers submitting studies, DHS will measure the number of training sessions offered to providers; the number of entity participants attending trainings; and the number of training video views.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			1,206	1,794	3,000	2,000	2,000	4,000
HCAF								
Federal TANF								
Other Fund								
Total All Funds			**1,206**	**1,794**	**3,000**	**2,000**	**2,000**	**4,000**
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	19 FTEs – salary, fringe benefits and overhead cost	1,773	2,638	4,411	2,941	2,941	5,882
GF	Rev 1	Admin FFP @ 32%	(567)	(844)	(1,411)	(941)	(941)	(1,882)
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	Background Studies FTEs	**17.0**	**17.0**		**19.0**	**19.0**	

Change Item Title: Background Studies Fee Changes

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	52	52	52	52
Revenues	0	0	0	0
Other Funds				
Expenditures	570	606	644	680
Revenues	(570)	(606)	(644)	(680)
Net Fiscal Impact = (Expenditures – Revenues)	52	52	52	52
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends increasing the background study fee to $44 for many study types to recover the actual costs of completing background studies. The legislatively established fee of $42 is below the average cost to conduct a study, as it does not account for the Minnesota Bureau of Criminal Apprehension (BCA) transaction fee increases reflected in the most recent interagency agreement between the Department of Human Services (DHS) and the BCA.

The Governor also recommends statutory amendments to support the department's efforts to maintain long-term stability by authorizing the department to raise background study fees in response to a BCA fee increase, and to allocate general funds to recover the cost of studies conducted for tribal organizations under 245C.34 for adoption and child foster care. Funds requested in this proposal will be used to cover the cost of background studies that exceed what the department is able to recoup from current fees assessed to individuals and entities seeking background studies.

Rationale/Background:

The Background Studies Division (BGS) within DHS is statutorily responsible for performing many complex functions within a highly regulated industry while also operating as a fee-for-service enterprise. The funding model for the division relies heavily on special revenue generated from fees to support the operation and long-term sustainability of the background studies program. DHS conducts background studies for over 70 provider types, encompassing over 35,000 active providers, many of which have unique study requirements outlined in Minnesota Statutes chapter 245C.

Since FY2018, DHS has seen a 45.5 percent increase in the number of background study applications received. In FY 2018, DHS received 374,292 background study applications; in FY 2019, the number increased to 424,660, and by FY 2022 that number increased to 544,540. This increase in demand for background studies is anticipated to continue as provider types requiring background studies are added and workforce shortage issues are addressed in fields that require a background study.

While DHS background study fees were raised from $20 to $42 in 2021, the fee increase did not account for the recent increase, as outlined in a new interagency agreement, in the cost to process background studies and criminal history checks at the BCA. DHS pays fees to the BCA for each study, as well as fees to the FBI when FBI studies are required. Those fees are entirely outside DHS' control.

This proposal ensures the Background Studies Division is able to meet the rising costs associated with conducting background studies, perform the required and complex work of conducting critical background studies for positions that support Minnesota's workforce needs, and protect the safety of children and vulnerable adults.

Proposal:

This proposal is a change to the fee structure for certain existing background studies, and grants DHS the authority to increase fees by the amount the BCA increases fees in the future. It adds to statute the ability to recover the costs of tribal background studies for adoption and child foster care and allocates funds to cover said costs of tribal background studies.

This proposal will bring background study fees in alignment with costs by:

- Increasing background study fees as outlined in 245C.10 from $42 to $44 per study, childcare studies currently set at $40 will also increase to $44 per study
- Increasing study fees currently set at $51 per study to $53 per study
- Allocating general funding to DHS to cover the costs of background studies for tribal organizations for adoption and child foster care.

The outcomes of this proposal include:

- Addressing escalating costs to conduct background studies and criminal history searches
- Recovering the costs of tribal background studies for adoption and child foster care

2021	2023	
$18.75	$18.75	DHS processing costs, including staff costs for research, obtaining criminal records, eligibility determinations, notices to study subjects/providers, help desk inquiries, NS2 help desk, system maintenance and department indirect costs.
$2.00	$3.00	BCA Name and Date of Birth Minnesota Records Search - electronic
$15.00	$15.00	BCA Name and Date of Birth Minnesota Records Search - manual
$5.00	$6.00	BCA Fingerprint-based Minnesota Records Search - electronic
$15.00	$15.00	BCA Fingerprint-based Minnesota Records Search - manual
$18.25	$18.25	FBI processing for national criminal history records information (CHRI)

The overall impact of the proposal would provide additional revenue in the Background Studies Special Revenue Fund in the amount of $1.2 million in the 2024-2025 biennium and $1.3 million in the 2026-2027 biennium. There would be an on-going annual cost of $52 thousand to the general fund for background studies for tribal organizations. Without the revenue from a fee increase during FY 2024 and 2025, an additional $1.2 million is needed by BGS in FY 2024-25 to correct the structural deficit in the special revenue account and to meet all statutory obligations.

The proposed change to the fee schedule would apply to approximately 249,700 studies in FY 2024 and 265,864 applications in FY 2025, resulting in estimated increased annual revenue of $570 thousand in FY 2024, and $607 thousand in FY 2025 in the special revenue fund. The proposed changes do not impact study fees negotiated through interagency agreements, guardian and conservator fees, or private agency fees.

Impact on Children and Families:

The proposal protects the health, safety, and rights of those receiving services from DHS and other state agency programs while contributing to the availability of an appropriately vetted workforce for providers serving vulnerable children and adults.

Equity and Inclusion:
DHS background studies impact the safety and quality of child care, adoption, foster care, physical and mental health services, and other programs serving children and vulnerable adults where Black, Indigenous, People of Color, those identifying as LGBTQ+, and other marginalized populations are disproportionately represented.

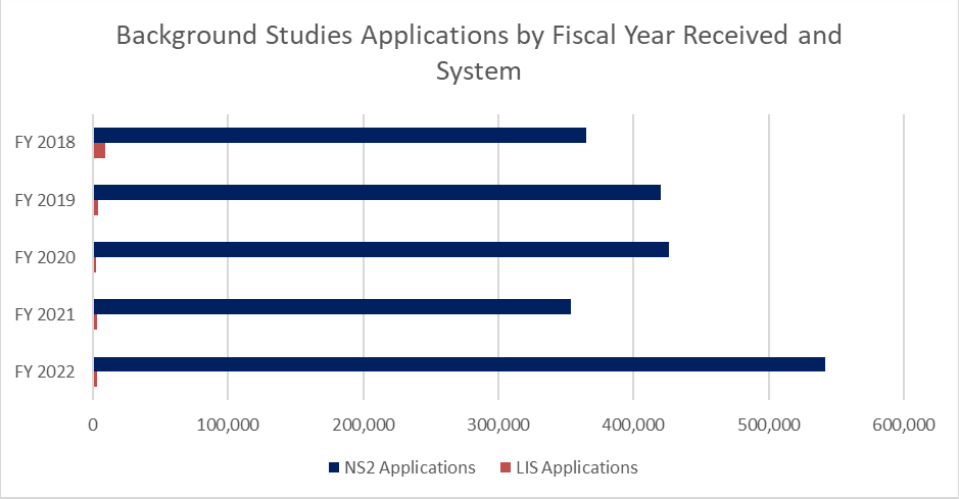
Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

All eleven tribal governments in Minnesota are impacted by this proposal. Tribal agencies seeking to have DHS conduct background studies for adoption and child foster care will enter into agreements with DHS to conduct these studies. This proposal includes a general fund appropriation to cover the costs of the studies as to avoid financial burden on Tribes.

Impacts to Counties:
Counties paying the background study fee for employment studies will experience a $2 increase in the cost per study from the current $42 rate. The total increase in expenditures is dependent upon the number of background studies sought per year by an individual county. Counties that seek a high number of background studies may experience a greater financial impact than those who pay for very few studies.

Results:
The number of background study applications received by DHS continues to grow. Since FY 2018, the number of background study applications received has increased by 45.5 percent. This increase in demand for background studies is anticipated to continue as provider types requiring background studies are added, and workforce shortage issues are addressed in fields that require a background study. A fee increase to recover the costs associated with changes to the BCA fee structure will have a significant positive financial impact on the operating budget for DHS' Background Studies Division.



Fiscal Year	LIS Applications	NETStudy 2.0 Applications	Total Applications
FY 2022	2,787	541,753	544,540
FY 2021	2,814	353,733	356,547
FY 2020	2,287	426,590	428,877
FY 2019	4,209	420,451	424,660
FY 2018	9,402	364,890	374,292

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			52	52	104	52	52	104
HCAF								
Federal TANF								
Other Fund								
Total All Funds			52	52	104	52	52	104
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	Background studies for tribal organizations	52	52	104	52	52	104
SR	11	Additional Fee Revenue	570	606	1,176	644	680	1,324
SR	11	Additional Study Costs	(570)	(606)	(1,176)	(644)	(680)	(1,324)
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Change Item Title: Fraud Prevention Investments for Tribal Nations

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	496	112	112	112
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	496	112	112	112
FTEs	**1**	**1**	**1**	**1**

Recommendation:
The Governor recommends $496 thousand from the general fund in FY 2024 and $112 thousand each year thereafter for fraud prevention programs for tribal nations. This includes $400 thousand in grant funding as well as one full-time employee (FTE) at the Minnesota Department of Human Services (DHS), Office of Inspector General (OIG) to serve as a tribal liaison.

Rationale/Background:
The Surveillance and Integrity Review (SIRS)/Recipient, Audit, Screening, and Contract Oversight (RASCO) program in the Office of Inspector General (OIG)-Financial Fraud and Abuse Investigation Division (FFAID) at the Minnesota Department of Human Services (DHS) recognizes that there is no simple solution to avoid fraudulent activity in needs-based benefit programs. In Minnesota, each county and tribe engages in their own fraud prevention activities either with or without the assistance of the state grant program. Better collaboration with county and tribal partners will lead to a more accurate and equitable determination for program funding as well as in a more consistent process with other administrations at DHS. As OIG-FFAID examines the current and future of the Fraud Prevention Investigations (FPI) and Fraud Control Program (FCP), this proposal offers an opportunity for an enhanced partnership with the Red Lake, White Earth, and Mille Lacs tribes.

The White Earth Nation is currently engaging in fraud prevention work by submitting cases to the Fraud Application System Environment (FASE) system but has the desire to establish a more robust program. Due to unique circumstances within tribal nations, they do not have the financial capacity to pay for the cost of starting a fraud prevention program and waiting for reimbursement from the state under the FPI program. This proposal would grant seed money for the Red Lake, White Earth, and Mille Lacs tribes to establish their own fraud prevention programs with the goal of folding each into the FPI program within two to three years.

In pursuing a new model of the FPI program and recognizing unique needs of tribes, the OIG would greatly benefit from the addition of a permanent tribal liaison. This proposal is consistent with continuing a partnership between DHS and tribal nations regarding designating responsibilities to tribes to conduct human services work for their respective communities. The addition of a tribal liaison would enhance relationships between DHS-OIG and tribal nations. A more open and transparent line of communication will increase collaboration, consistency, and understanding of applicable policies, practices, and procedures.

Proposal:
This proposal allocates $400 thousand over the FY 2024-25 biennium to the Red Lake, White Earth, and Mille Lacs nations for each to develop their fraud prevention work. This allocation would go toward the tribes for hiring one

or more Fraud Prevention Investigators per tribe to oversee the fraud prevention work for the Red Lake, White Earth, and Mille Lacs nations and would be available through FY 2025. Providing a start-up grant would ensure the tribes are set up for success including access to necessary databases, reporting software, technology, staff training, and support. The goal, with this startup funding and support, will be to fold the tribes into the larger DHS FPI program that provides quarterly reimbursements for fraud prevention work.

This proposal also seeks funding for one FTE to serve as a tribal liaison for the DHS Office of Inspector General. In addition to serving as a central source of communication between FFAID and the three tribal nations in the implementation of this proposal, the tribal liaison will have the following duties:

- To coordinate legislative, policy, service delivery, and compliance activities for the Office of Inspector General (OIG);
- To provide technical expertise on complex state and tribal policies to assist with implementing strategies; and
- To engage, confer, and coordinate with tribal stakeholders concerning DHS policies and practices.

Impact on Children and Families:

This proposal will help support tribal nations begin and/or expand their fraud prevention work for needs-based benefits programs. Tribal nations will be able to more efficiently, consistently, and effectively administer, audit, and investigate their needs-based benefit programs. Efficient and consistent fraud control and fraud prevention programs will lead to a more effective use of taxpayer and DHS money for vulnerable and future Minnesotans. This work will also instill confidence that eligible benefit program recipients receive their benefits and investigations of potential misconduct are done without bias or adverse impact on eligible benefit recipients.

Equity and Inclusion:

This proposal addresses inequities for tribal nations and supports establishing a robust fraud prevention program. Collaborating with tribal nations, being responsive to the communities' needs, and providing a venue of communication via a tribal liaison will better support tribal partners. Positive indirect impacts include a more efficient and effectively utilized needs-based benefit programs that are administered by tribal nations. This work will also instill confidence that eligible benefit program recipients receive their benefits and investigations of potential misconduct are done without bias or adverse impact on eligible benefit recipients.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

This proposal will financially and operationally impact tribes. Allocated funding to begin and/or expand fraud prevention work will set tribes up for success and future folding into greater DHS FPI program. Tribal nations will receive support in the form of money, initial and continued training, programming infrastructure, and DHS support. These activities will lead to more robust recipient fraud prevention and detection activities that will positively affect performance measures related to recoveries, restitution, and cost avoidance.

This proposal will decrease rates of disparities and disproportionality across all tribal nations by developing a governance and best practices model to increase consistency of fraud prevention practices across Minnesota. This work will instill confidence that eligible benefit program recipients receive their benefits and investigations of potential misconduct are done without bias or adverse impact on eligible benefit recipients.

Per the DHS Office of Indian Policy, fraud prevention work with the tribes is identified as a funding priority. Providing dedicated funding and support will set tribal nations up for success to request and implement grant funds from the state in the future. These activities will lead to more robust recipient fraud prevention and

detection activities that will positively affect performance measures related to recoveries, restitution, and cost avoidance. Dedicating a tribal liaison for DHS-OIG will ensure open lines of communication with tribal nations, ensuring a partnership based on community needs.

Impacts to Counties:

This proposal does not financially impact counties.

Results:

Performance measures include an increased number of cases entered into the OIG-FFAID FASE system, the hiring of a tribal liaison, and the hiring of a fraud prevention investigator for the Red Lake, White Earth, and Mille Lacs region. Measures of effective program implementation include quality measures such as enhanced relationships with tribal nations, and an increased trust from the public and benefit program recipients. Evidence based evaluation will include a holistic and robust analysis of the effectiveness of the developed program. Quantitative measures can be used to determine the utilization and effectiveness of the program, including data in the OIG-FFAID FASE case tracking system. Recipients of needs-based benefit programs will be better off upon implementation and completion of this proposal.

IT Related Proposals:

This proposal does not have IT impacts.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			496	112	608	112	112	224
HCAF								
Federal TANF								
Other Fund								
Total All Funds			496	112	608	112	112	224
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	Start-up grants to Tribal governments	400	0	400	0	0	0
GF	11	1.0 FTE: Human Services Program Consultant (17L)	141	165	306	165	165	330
GF	Rev1	Admin FFP @ 32%	(45)	(53)	(98)	(53)	(53)	(106)
		Total Net Fiscal Impact	496	112	608	112	112	224
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 22**	**FY 23**	**FY 22-23**	**FY 24**	**FY 25**	**FY 24-25**
			1	**1**	**1**	**1**	**1**	**1**

Change Item Title: Modernize Adult Residential Mental Health Rule

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	132	216	247	109
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	132	216	247	109
FTEs	**2**	**2**	**2**	**2**

Recommendation:

The Governor recommends $348 thousand in FY 2024-25 and $356 thousand in FY 2026-27 from the general fund for staff and administrative resources to consult with stakeholders, draft rule changes, complete the rulemaking process to amend these standards, and implement the new requirements. Licensing standards for residential adult mental health programs are 40 years old and need to be modernized to accurately reflect different levels of care. This process will require temporary staff in the Licensing Division and administrative costs to amend Minnesota Rules.

Rationale/Background:

Licensing standards for residential adult mental health programs in Minnesota Rules, Parts 9520.0500 to 9520.0670 (Rule 36) became effective in 1982. There have been no substantial changes since to this rule. In 2005, most adult residential programs were transitioned to new standards under the Intensive Residential Treatment Services (IRTS) variance to make these a Medicaid billable service. The IRTS variance required the programs to provide a higher level of care under more up to date standards instead of the outdated rule requirements. The IRTS standards then existed informally in a variance for 17 years and are just now transitioning into Minnesota Statutes, chapter 245I as part of the Uniform Service Standards (USS) project. There are however still several programs that provide different levels of care and have a higher capacity that are not appropriate for an IRTS license. This includes the Forensic Mental Health Program (formerly the Minnesota Security Hospital), longer term residential programs funded through counties, and programs for people with eating disorders.

The Forensic Mental Health Program (FMHP) currently operates under a different variance to Rule 36 that contains requirements which reflect the program's secure setting for adults who have been committed to the care of DHS as mentally ill and dangerous. The variance standards were created in partnership with clients and the FMHP due to the inadequacy of Rule 36 and the lack of appropriate requirements for one of the highest levels of mental health treatment in the state. Creating variance standards followed a time period when the FMHP was placed on a conditional license status and monitoring of requirements absent from Rule 36 was necessary, including oversight of the use of seclusion and physical restraints. Development of variance requirements included multiple stakeholder meetings and communication with legislators. Monitoring of these requirements and many others is important to the health and safety of the clients at the FMHP and should not continue to exist in a variance outside of any formal rule or statute.

The other residential mental health programs still operating under Rule 36 serve clients who need less intensive treatment services and may live at the program for several years. New standards should be developed that accurately reflect this level of service while also reflecting current mental health best practices. Programs for people with eating disorders will likely be able to operate under similar standards.

The current rule includes two different types of programs, category one and category two. Category one is the higher level of care and these programs are residential settings that focus on mainly providing services at the program. Category two programs are the lower level and are transitional semi-independent or a supervised group supportive living settings that can offer services at the program but emphasize community resources for most services. Currently all 8 programs licensed under Rule 36 are Category one programs and there are no licensed category two programs. Because category two programs rely on services in the community and there are now other housing models like permanent supportive housing to fulfill this role, category two is no longer necessary and would be eliminated.

Transitioning the Forensic Mental Health Program variance to rule will establish a clear legal foundation for these standards. Current standards for category one programs are outdated and programs and clients will benefit from standards that align with current best practices, such as a definition for a mental health professional that requires the person to be licensed. Removing category two program license requirements will allow mental health programs that provide supportive services, but do not directly provide mental health treatment, to operate without a DHS program license.

Proposal:

This proposal funds updates to these 40-year-old standards in a way that ensures the adequate monitoring of the health and safety needs of the clients receiving services. The Licensing Division will need two short-term staff positions for only three years to accomplish this. These positions will begin by consulting with programs, clients, other state agencies, and additional stakeholders to determine what changes the rule will need. They will then be responsible for amending the rule including: drafting the rule language; drafting the Statement of Need and Reasonableness (SONAR), giving notice about the rulemaking process to various stakeholder groups and the public; preparing for and speaking at hearings; responding to comments about the substance of the rule; and completing an equity analysis of rule changes. The rule changes will include:

- codifying the Forensic Mental Health Program variance standards into Minnesota Rules
- updating the standards for category one programs to align with current practices, and
- eliminating category two programs which should not require a license to operate.

Once the rule amending process is complete, these staff will be responsible for training providers on the new standards and creating templates and forms to assist programs to comply with the new requirements. They will also train licensors, update DHS electronic monitoring checklists with the new requirements, and complete all other steps necessary for DHS to implement the requirements.

Rulemaking costs in this proposal include Office of Administrative Hearings Administrative Law Judge hourly fees, filing fees, and state register publishing costs.

DHS electronic systems will require updates and there will be costs to update the Licensing Information Lookup (LIL) and the Electronic Licensing Management System (ELMS) to reflect the new license type categories and rule citations.

Impact on Children and Families:

This proposal mainly impacts adults. Families of clients in these programs will have greater confidence that DHS is monitoring the services they are receiving in a way that aligns with current practices in the mental health field.

Equity and Inclusion:
More up to date requirements will benefit people with mental health disabilities in these programs by ensuring the provider is following standards that are in line with contemporary mental health practices. DHS will complete an equity analysis of the rule changes as part of the rulemaking process.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒ No

Impacts to Counties:
No financial impact to counties are expected. County case workers place clients in these programs and continue to work with clients while in a program. Improving and updating the program standards will allow county workers to clearly understand the program's responsibilities for their clients. DHS will consult with the counties as part of the rulemaking process to address any needs or concerns.

IT Costs:
Existing DHS electronic systems for recording program information and compliance history will require minor updates to reflect the new license type categories and rule citations. These systems include the Licensing Information Lookup (LIL) to inform the public about program information and any recent noncompliance with requirements and the Electronic Licensing Management System (ELMS) that licensors use to record information about the program, inspections, and compliance history.

Category	***FY 2024***	***FY 2025***	***FY 2026***	***FY 2027***	***FY 2028***	***FY 2029***
Payroll						
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)			$3,762	$752	$752	$752
Total			$3,762	$752	$752	$752
MNIT FTEs	0	0	0	0	0	0
Agency FTEs	0	0	0	0	0	0

Results:
Establishing a clear legal foundation for these standards will prevent future legal issues with enforcing requirements not established in rule or law. Aligning program requirements with current practices in mental health will allow DHS to review these programs in a more meaningful way for standards that encourage positive impacts to a clients' mental health.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			132	216	348	247	109	356
HCAF								
Federal TANF								
Other Fund								
Total All Funds			**132**	**216**	**348**	**247**	**109**	**356**
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	Salary, fringe benefits, and overhead cost: 2 FTEs	194	318	512	318	159	477
GF	11	Rulemaking	0	0	0	40	0	40
GF	11	MN.IT Development and Maintenance Costs: ELMS	0	0	0	4	1	5
GF	REV 1	Admin FFP @ 32% of salary, fringe benefits and overhead costs	(62)	(102)	(164)	(115)	(51)	(357)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
			2	2		2	2	

Change Item Title: Family Child Care Continuous Licenses

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	708	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)	**708**	0	0	0
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends implementing a continuous license process for family child care license holders to reduce redundant application requirements. This proposal has a one-time cost to the general fund of $708 thousand in FY 2024 and will not impact the Licensing Division's base budget. This recommendation would support the infrastructure needed to transition to a continuous license, including IT systems costs. To help with this transition, the department proposes to cover initial application and annual licensing fees for family child care license holders for two years.

Rationale/Background:

Laws of Minnesota 2020, 1st special session, chapter 2, article 1, section 24 directed DHS to consult with license holders and county agencies to determine whether family child care licenses should automatically renew instead of requiring license holders to reapply for licensure. DHS Licensing held webinars with family child care license holders and licensors who generally supported the idea. This idea was also supported by the Family Child Care Task Force (2019-2021), which recommended that DHS develop a continuous licensing process with input from licensors and license holders.

This proposal reduces redundant application requirements for family child care license holders. Under current rule and statute, licensed family child care license holders are typically given two-year licenses. License holders have to formally reapply to extend the term of their license, which includes filling out the application again. This would streamline the licensing reapplication process and reduce the amount of time license holders and licensors spend on licensing documents. It also mirrors the process used by most other DHS-licensed services.

This proposal makes the licensing review cycle easier for family child care license holders and licensors. License holders will need to track that they completed licensing requirements in a calendar year rather than following a year aligned with their license anniversary date. This will give license holders an easy way to track when requirements such as training are due, and give them the flexibility to complete requirements at any time during the calendar year. It will also give licensors the flexibility to visit programs at different times of the year.

This proposal will increase consistency among counties. Instead of counties using different forms and processes to renew a license, all counties will use the new licensing, registration, and reporting hub to update information between licensing reviews.

Proposal:

After consulting with stakeholders, the Governor recommends adoption of a continuous license, or a license that automatically renews, for family child care license holders. All family child care licenses would be on a calendar year cycle (January – December) rather than expiring after one or two years. License holders would not need to complete a new license application when their old license expires, but rather they would provide updates in an online provider hub if any of their information changes. This will reduce administrative burdens for both license holders and licensors.

Annual licensing inspections would no longer align with the license holder's license anniversary date. This means a licensor could visit a program in the summer one year and in the winter the next year. This will give licensors a better idea of a program's compliance throughout the year, rather than during the season of their license anniversary date.

Licensing requirements would also be tied to a calendar year cycle. Licensors will review family child care programs for compliance based on the previous calendar year, not the time period between license anniversary dates. This timeline will likely be more straightforward for license holders and licensors alike.

Currently, counties collect licensing fees from family child care license holders throughout the year based on when their license expires. With a continuous license, DHS would collect licensing fees on behalf of the counties at one time of the year and then distribute the funds back to the counties. This proposal seeks one-time funding to cover family child care initial application and annual licensing fees for two years. This will give counties and license holders time to adjust to this new cycle.

Impact on Children and Families:

This proposal could benefit families because licensors will review programs at different times of the year and can identify health and safety concerns in different seasons. For example, a family child care program that uses a pool will need to have different safeguards in place in the summer than it does in the winter.

By reducing administrative tasks, this proposal allows license holders to focus on caring for children and planning activities to promote learning and development.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:

This proposal will impact counties in a number of ways.

- It will allow county licensors to have more flexibility in their licensing review schedules. Licensors will be able to visit a program at any time during a calendar year rather than visiting it during a time period tied to its license anniversary date.
- County licensors will need to adjust how they monitor family child care programs. Instead of looking back at the year since their license anniversary date, licensors will review the previous calendar year.
- It will impact the timeline and manner in which licensing fees are collected. DHS will collect family child care licensing fees and then distribute the funds back to the counties. This means instead of collecting fees throughout the year, the counties will need to adjust their budgets and processes to accommodate one lump sum.
- It will make family child care licensing fees consistent across counties.

IT Costs:

The new Provider Licensing and Reporting Hub and the SWIFT interface will need to be updated to accommodate the new licensing schedule and fee collection process. This will allow licensing application and renewal fees to be collected in the Provider Licensing and Reporting Hub and passed back to the counties on an annual basis.

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll						
Professional/Technical Contracts	225,000					
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)						
Total	**225,000**					
MNIT FTEs						
Agency FTEs						

Results:

This proposal will increase quality in family child care programs in a number of ways:

- It will create a more seamless process so that we can provide better customer service to license holders and licensors.
- It will align with the department's child care systems transformation project to move away from a paper system and adopt a system with electronic license applications, Child Care Assistance Program provider registration, provider management, provider reporting, and compliance monitoring.
- It will create greater consistency among counties.
- It will allow licensors to visit programs at different times of the year, so they can see how the program is set up in the winter versus the summer, for example.
- It will improve alignment with federal Child Care and Development Block Grant reporting requirements.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			708	0	708	0	0	0
HCAF								
Federal TANF								
Other Fund								
Total All Funds			708	0	708	0	0	0
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	Payments to Counties for Lost Licensing Revenue	652	0	652	0	0	0
GF	11	Child Care Licensing System Development Costs: Salesforce	56	0	56	0	0	0
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

Minnesota Statutes, 245A.02, subd. 2c
Minnesota Statutes, 245A.50, subd. 3
Minnesota Statutes, 245A.50, subd. 4
Minnesota Statutes, 245A.50, subd. 5, paragraph (e)
Minnesota Statutes, 245A.50, subd. 6
Minnesota Statutes, 245A.50, subd. 9, paragraph (d), clause (2) and paragraph (e)

Change Item Title: Financial Fraud and Abuse Investigations (FFAID) Program Integrity Enhancements

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	737	713	600	600
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	**737**	**713**	**600**	**600**
FTEs	**6.0**	**6.0**	**5.0**	**5.0**

Recommendation:

The Governor recommends investing $1.450 million in FY 2024-25 and $1.2 million in FY 2026-27 from the general fund for public integrity enhancements within the Office of Inspector General's (OIG) Financial Fraud and Abuse Investigation's Division (FFAID) focused on: 1) development, implementation and on-going administration of responsibilities established by amendments to the limits on receiving public funds statute (Section 245.095); and 2) development and facilitation of provider training through web-based and in-person platforms that are responsive to county partners and Child Care Assistance Program (CCAP) provider feedback, as well as identified program integrity challenges.

Rationale/Background:

Related to the proposed amendments to the limits on receiving public funds statute, under current law DHS does not have the authority to disqualify or suspend providers due to a suspension or disqualification by other state and federal agencies. Additionally, DHS does not have the authority to temporarily withhold payments due to suspected fraud and an ongoing investigation in a program administered by another state or federal agency. These proposed amendments and corresponding budget proposal are required to strengthen the state's ability to quickly identify and mitigate fraud risks across DHS programs.

In addition, the proposal addresses needs identified by Minnesota counties and child care providers. One aspect of program integrity is preventing fraud from occurring. Proper and frequent training is one way to effectively prevent fraud and fraud investigations. DHS recognizes a need for more robust training for providers and partners across the state of Minnesota related to program integrity and requirements. This proposal seeks to allocate staffing resources to develop and facilitate training through web-based, on-demand, recorded webinars, and in-person platforms that is responsive to provider and partner feedback as well as identified program integrity challenges. Providing consistent and proactive communications will increase the understanding and implementation of provider rules and policies. A focus on proactive education over reactive enforcement will decrease administrative errors and positively impact trust between providers, partners, the community, and OIG-FFAID.

Proposal:

This proposal has two distinct focus areas, as described below.

Limits on Receiving Public Funds

This proposal amends Minnesota Statutes 245.095 to allow DHS to take the following actions against providers that have been excluded from public funds administered by another Minnesota state agency or a federal agency:

- Prohibit the excluded provider, vendor, or individual from enrolling, becoming licensed, receiving grant funds, or registering in any other program administered by the commissioner;
- Disenroll, revoke or suspend a license, disqualify, or debar the excluded provider, vendor, or individual in any other program administered by the commissioner.

In addition, the proposal allows DHS to suspend payments to providers when there is a credible allegation of fraud for which an investigation is pending for a program administered by a Minnesota state agency or a federal agency. Finally, the proposal requires DHS to give notice to the affected providers, and it gives those providers appeal rights.

To support the development, implementation and on-going administration of the amended statute, the proposal includes funding for 4 FTEs: a Human Services Program Coordinator (MAPE 20L) responsible for coordinating responsibilities under this statute for the OIG; a temporary Human Services Program Consultant (MAPE 17L) responsible for developing and implementing a data analytics plan for FFAID; a Staff Attorney 2 (MAPE 19L) to support legal determinations and potential adjudications of actions taken under this statute; and an Agency Policy Specialist (MAPE 17L) to support the on-going data and analytics requirements of this statute. Funding is also included for IT system modifications focused on improving cross-system tracking and reporting, as well as adjudication-related expenses tied to the appeal rights provisions of the amended statute.

Program Integrity Education and Training

This proposal funds two FTEs (Human Service Program Representatives 2 – MAPE 14L) to create, implement and maintain training and educational resources for county partners and child care providers. There are currently no staffing resources dedicated to this work, as highlighted by frustrations communicated by county partners and the CCAP community as well as inconsistencies in record keeping by providers. These positions will create a robust training program that is responsive to the needs of county partners, Child Care Assistance Program (CCAP) providers, and DHS stakeholders, and promote open lines of communication about emerging issues and challenges. The hiring process is anticipated to begin upon implementation by the Legislature on July 1, 2023.

This proposal will strengthen relationships between DHS, county partners, CCAP partners, and the community. This will result in increased public trust of the investigative work conducted by OIG-FFAID. Providing consistent and proactive communications will increase the understanding and implementation of provider rules and policies, leading to fewer investigations and enhanced relationships with county partners and CCAP providers. A focus on proactive education over reactive enforcement will positively impact trust between providers, partners, the public, legislators, and DHS.

Impact on Children and Families:

Related to the amendments to the limits on receiving public funds, this proposal would significantly improve DHS's ability to expediently respond to circumstances where there is a preponderance of evidence that fraud has taken place by actions against providers that have been excluded from public funds administered by another Minnesota state agency or a federal agency. Reducing instances of fraud allows greater assurance that public funds are being spent to support legitimate programs serving children and families.

This proposal also seeks to increase efficiency and streamline processes for counties and child care providers by providing proactive communication, training, and education. Child care providers may continue to offer and/or increase CCAP openings because they feel more confident utilizing the program due to better training

opportunities. Families and children will not be directly affected, but may feel indirect positive impacts from counties and child care providers.

Equity and Inclusion:
This proposal addresses inequities for people of color, Native Americans, people with disabilities, people in the LGBTQ community, other protected classes, or veterans by improving trust in communities that have been disproportionately impacted by OIG-FFAID investigations. A proactive, educational approach that is responsive to community demographics, lived experience, and needs will lead to more effective utilization of funds, fewer investigations, and increased community trust. Training and education materials will be inclusive and responsive to the community, ensuring the information is effectively received. Because people receive information in different ways, creating a training program offers the opportunity to create materials in different languages and different formats to effectively reach members of different communities. Indirect positive impacts could include the current level of or increase of CCAP openings from child care providers.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
X No

This proposal seeks to decrease rates of disparities and disproportionality. Tribes will be engaged when staffing resources are allocated to accurately assess training needs, and in developing training modules. OIG-FFAID will work with DHS Tribal Nation liaisons to for education, communication, and collaboration.

Impacts to Counties:
This proposal is not expected to impact county finances or operations. Counties will be positively impacted by having training that delivers consistent information from DHS about the processes and procedures for administering state funding and medical assistance reimbursements.

This proposal seeks to decrease the rates of disparities in and across counties. Counties will be engaged when staffing resources are allocated to accurately assess training needs, and in developing training modules.

IT Costs:
IT costs will consist of IT system modifications focused on improving cross-system tracking and reporting, as well as licenses for necessary software programs to ensure the needs for a robust training program are met. Specialty computer programs will ensure the flexibility to be responsive to community needs as well as maneuverability across different training platforms. The cost for an alignment is valuable for professional development, creative and effective suggestions on training, and staying current with best practices.

Costs:

- Limits on Receiving Public Funds: $250 thousand in FY 2024 for IT system modifications focused on improving cross-system tracking and reporting
- Program Integrity Education and Training: $5 thousand in FY 2024 and $4 thousand in FY 2025, FY 2026 and FY 2027 for software to develop and delivery training.

Results:
Related to the amendments to the limits on receiving public funds the OIG would closely track all determinations and actions taken under the proposed expansion of statutory authority, including savings from fraudulent activities.

Performance measures include the number of training sessions offered and attended, the number of views for a webinar or online module, and the number of times an online document was viewed or downloaded. Feedback from training participants will be solicited to ensure that training content and delivery is administered in an effective way. Results are expected to show that county officials and CCAP providers are better off utilizing applicable DHS programs through a better understanding acquired through training and educational materials.

Evidence based evaluation will include a holistic and robust analysis of the effectiveness of training and outreach conducted by the addition of two FTEs. Measures of effectiveness include quality measures such as enhanced relationships with county partners and CCAP partners, more collaborative meetings between providers, partners, and investigators, and increased public trust. Quantitative measures that can be used to determine the utilization and effectiveness of educational resources included the number of views or hits for online resources, a lower error rate during investigations, fewer investigations, and fewer overpayment recoveries.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			737	713	1,450	600	600	1,200
HCAF								
Federal TANF								
Other Fund								
Total All Funds			737	713	1450	600	600	1200
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 24-25**
GF	11	6 FTEs - Salary, fringe benefits, and overhead cost (6,6,5,5)	846	995	1,841	830	830	1,660
GF	11	IT System Modification (State Share 50%)	125	0	125	0	0	0
GF	11	IT Software (State Share 50%)	3	2	5	2	2	4
GF	11	Appeal adjudication costs	50	50	100	50	50	100
GF	REV 1	Admin FFP @ 32%	(287)	(334)	(621)	(282)	(282)	(564)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
			6	6		5	5	

Statutory Change(s):

Changes to 245.095.

Change Item Title: New Chapter for Public Law Background Studies

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	170	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)	170	0	0	0
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends a one-time general fund investment of $170 thousand in FY 2024 for the Department of Human Services (DHS) Background Studies Division to fund IT systems changes and provide operational support necessary for Minnesota to comply with federal regulations. This recommendation will create a new state statute, Chapter 245J (Department of Human Services Public Law Background Studies Act), to comply with Federal Bureau of Investigation (FBI) requirements that enable DHS to receive national criminal record information for background studies authorized under Public Law 92-544. Currently, the Minnesota Sex Offender Program (MSOP) is the only entity with background studies authorized under Public Law 92-544, though the new chapter would accommodate study types with that authorization that may be added in the future.

Rationale/Background:

The DHS Background Studies Division regularly confers with the FBI and Bureau of Criminal Apprehension (BCA) about chapter 245C and other relevant areas of statute to ensure compliance with federal requirements. Discussions with the FBI and BCA in 2020 revealed problems with DHS background studies meeting the requirements of Public Law 92-544, which DHS has cited as the authority to receive national criminal history record information for most background study types.

Leading up to the 2021 legislative session, DHS worked with the BCA to change the basis of authority for most background study types from Public Law 92-544 to the National Child Protection Act, as amended by the Volunteers for Children Act (NCPA/VCA (34 U.S.C. § 40102)). [See also Minn. Stat. §299C.62, subd. 2 for the BCA's corresponding state language.] The NCPA/VCA authority covers receipt of criminal history for individuals providing services for children, the elderly, and individuals with disabilities. This basis of authority change was included in the 2021 Governor's Budget.

During the 2021 legislative session, DHS sought BCA approval to change the basis of authority for appropriate background studies to NCPA/VCA. The Department of Public Safety (DPS) General Counsel and BCA staff denied approval of the MSOP provider type, determining that the program was not providing services for children, the elderly, or individuals with disabilities. DPS and BCA's legal analyses recommended that DHS seek to use Public Law 92-544 as the authority for MSOP studies.

DHS, in consultation with the BCA, drafted an amendment to the health and human services omnibus bill creating 245C.032, which defined and established the process for public law background studies. MSOP was the only study type covered by that section. The new section 245C.032 was included in the health and human services bill passed by the legislature and signed by the governor in 2021. Staff working in MSOP continued having emergency

background studies (using name and date-of-birth studies of Minnesota records only that were implemented during the COVID-19 pandemic) pending FBI review of 245C.

In May 2022, the FBI informed DHS via the BCA that they denied approval of MSOP background studies under 245C.032 with Public Law 92-544 as the federal authority for DHS to receive national criminal history record information. In determining that 245C.032 does not meet the requirements of Public Law 92-544, the FBI cited: vague language in 245C, specifically in:

- the definition of public law background study;
- the category of individuals required to have a background study under the public law authority;
- the reference to private agencies in 245C that conflicts with the Public Law 92-544 prohibition against dissemination of FBI criminal history record information to private agencies; and
- the references in 245C.032 to multiple sections of 245C. (The FBI cannot review the statute for requirements that apply to MSOP only but must review the entire chapter.)

After internal DHS review of options and consultation with the BCA, DHS determined the best course of action to ensure program integrity would be to extend name and date-of-birth studies of Minnesota records only until Minnesota obtains federal approval for MSOP background studies and to establish a new section of state law that will meet federal requirements.

Proposal:

This proposal makes changes to Minnesota Statutes**,** adding chapter 245J to ensure the department has the authority to receive national and state criminal history record information necessary to conduct background studies for individuals having direct contact with persons served by the licensed sex offender treatment program, MSOP, and for entities that may have studies authorized under Public Law 92-544 in the future. The proposal will repeal 245C.032, the section addressing public law background studies, which will be superseded by the new chapter.

With the codification in a new chapter of the process for Public Law 92-544 background studies that are completed by DHS, the FBI will be able to review the statute for requirements that apply to MSOP only, rather than assessing the entirety of 245C. This change addresses a key point raised by the FBI when they denied approval of MSOP studies. DHS is in close communication with the BCA and FBI while developing the new chapter and has a plan in place for their review of draft language.

Pending FBI approval of the chapter in its final form, DHS estimates that $250 thousand in systems updates would be necessary for accurate and clear communication with study subjects and providers about employment status and due process. DHS would also make any systems changes to accommodate a new workflow in compliance with any new requirements based on the FBI approval, and system changes to related to how and whether background study determinations might transfer, connect, or be affiliated across background study applications.

DHS would implement the new Minnesota Chapter 245J effective July 1, 2023. After the change is enacted, DHS will send the language to the FBI for their official review. When DHS obtains official FBI approval of the new chapter, the Background Studies Division will implement necessary IT systems changes. The MSOP program would then transition from name and date of birth studies of Minnesota records only to fully compliant, fingerprint-based studies conducted under 245J.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs:

DHS estimates that $250 thousand in systems updates would be necessary for accurate and clear communication with study subjects and providers about employment status and due process. DHS would also make any systems changes to accommodate a new workflow in compliance with any new requirements based on the FBI approval, as well as system changes to related to how and whether background study determinations might transfer, connect, or be affiliated across background study applications.

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll						
Professional/Technical Contracts	250,000					
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)						
Total	**250,000**					
MNIT FTEs						
Agency FTEs						

Results:

Success will be measured by FBI acceptance of the new language and DHS authorization to receive national criminal record information for background studies authorized under Public Law 92-544.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
General Fund			170	0	170	0	0	0
HCAF								
Federal TANF								
Other Fund								
Total All Funds			170	0	170	0	0	0
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	BGS contract for federal compliance systems changes	250	0	250	0	0	0
GF	REV1	Admin FFP @ 32%	(80)	0	(80)	0	0	0
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

245C and 245J

Change Item Title: Home and Community-Based Services Corporate License Application Fee

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	740	740	740	740
Revenues	(740)	(740)	(740)	(740)
Net Fiscal Impact = (Expenditures – Revenues)	**0**	**0**	**0**	**0**
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends increasing license fees for non-individuals (corporations) applying for a home and community-based services (HCBS) license. This fee increase would result in a projected increase in revenue of $740 thousand each year for the state government special revenue Fund (SGSR). This SGSR revenue would be appropriated back to the Department of Human Services (DHS) Licensing Division to pay for the resources used to process HCBS license applications.

Rationale/Background:

This recommendation seeks to address two problems. The first is that individuals and non-individuals (corporations) pay the same application fee for an HCBS license. The second issue is that the DHS HCBS license application fee is far less than the Department of Health's (MDH) application fee for a comprehensive home care provider license, which is a comparable license. Since the license fees are different for the two departments, applicants may apply for the less expensive license instead of the license that aligns with their business.

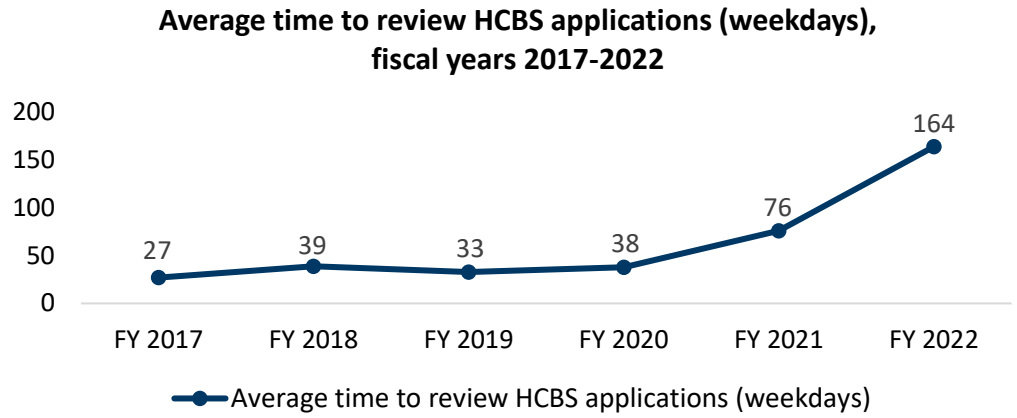
This recommendation will create a more equitable fee structure to address both issues. It will increase the license application fee for non-individuals (corporations) and align the fee with MDH's comparable license. The HCBS license application fee was set in 2003 and has not been adjusted since.

Proposal:

This proposal will create a more equitable fee structure for HCBS license applications. It will increase the license application fee for non-individuals (corporations) to account for the resources used to process applications and to align the fee with MDH's comparable license.

Currently both individuals and non-individuals (corporations) pay a $500 application fee for an HCBS license. Having the same application fee is not fair to individuals, especially since applications for non-individuals are more complex. Individuals, such as family adult foster care applicants will continue to pay $500 to apply for an HCBS license.

This proposal would also align the non-individual license application fee for an HCBS license with the Minnesota Department of Health's (MDH) application fee for a comprehensive home care provider license. Minnesota Statutes, Section 144A.472, Subdivision 7 requires applicants to pay $4,200 for MDH's comprehensive home care provider license. There are similarities between MDH's comprehensive home care provider license and DHS' HCBS license, so some applicants are selecting a license based on application fee rather than their competency to provide quality services. If DHS' fees aligned with MDH's application fees, applicants may be more inclined to apply for the license that best aligns with the services they are equipped to provide.



Equity and Inclusion:
This proposal will create a more equitable fee schedule for HCBS license applicants. It will maintain a lower license application fee for individuals and increase the fee for corporations. An applicant who is a family foster care and wants to apply to provide HCBS services would not be impacted by this proposed application fee.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
This proposal will not impact counties.

Results:

- In addition to the quantity measures identified below, we anticipate a positive result of having more HCBS applicants who are competent to provide HCBS services upon application.

Type of Measure	*Name of Measure*	*Previous (2015)*	*Current (2021)*	*Anticipated (with this proposal)*
Quantity	HCBS applications received	130	658	200
Quantity	HCBS applications withdrawals	1	56	10
Quantity	HCBS applications denied	0	35	10

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund								
HCAF								
Federal TANF								
Other Fund - SGSR			0	0	0	0	0	0
Total All Funds			**0**	**0**	**0**	**0**	**0**	**0**
Fund	**BACT #**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
SGSR	REV1	Revenue increase from HCBS applications	(740)	(740)	(1,480)	(740)	(740)	(1,480)
SGSR	11	Licensing HCBS Activities	740	740	1,480	740	740	1,480
		Total Net Fiscal Impact	**0**	**0**	**0**	**0**	**0**	**0**

Statutory Change(s):

245A.10, subd. 3

Change Item Title: Background Studies 245C Statutory Changes

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	409	269	269	157
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	**409**	**269**	**269**	**157**
FTEs	**2**	**2**	**2**	**1**

Recommendation:

The Governor recommends $678 thousand in FY 2024-25 and $426 thousand in FY 2026-27 to bring the department into compliance with federal regulations on data sharing related to background studies, specifically where state law has required an individual to share reasons for disqualification with a provider. This proposal will also require individuals to access background studies documentation electronically in the applicant portal thus streamlining the background studies notification process.

In order to implement these amendments, funding is necessary to:

1. Make changes to the content of the Adobe Experience Manager (AEM) notification letters sent to individuals and entities. MNIT estimates initial development for these changes to cost $52 thousand;
2. Make changes to the NETStudy 2.0 system necessary for individuals to electronically access background studies documentation. This build is expected to cost $52 thousand for initial changes, but ultimately to result in a cost savings of approximately $500 thousand per year;
3. Make changes to Microsoft Dynamics 365 CRM to manage and maintain work processes currently performed outside of NETStudy 2.0. This build is expected to cost $264 thousand for the initial build with ongoing maintenance fees of $53 thousand per fiscal year; and,
4. Pay for 3.5 FTE to plan for the technical needs associated with developing an electronic process that enables study subjects to submit appeals to request reconsideration of background study disqualification determinations. Temporary, unclassified FTE breakdown is as follows:
    - 1.0 FTE Management Analyst 4, 3-year temporary unclassified in Background Studies Division
    - 0.5 FTE MAPE 19L, OIG Legal Counsel
    - 0.5 FTE MAPE 16L, OIG Data and Analytics Office
    - 1.5 FTE MNIT for systems changes

Rationale/Background:

The DHS background study system was implemented in 1991; since that time, significant changes have been made to laws and standards for many health and human services programs. These programs serve ever-increasing numbers of the state's most vulnerable child and adult populations. More provider types are now required to submit background studies on new hires, and in some cases, studies must be submitted for their existing employees as well. Currently the department conducts background studies for over 70 provider types, with over 35,000 active providers requiring background studies.

Current statute requires individuals to share their disqualification letter with the provider under certain circumstances, and it separately requires the department to notify the provider of the reason for the disqualification when granting a set aside or variance. This requirement to share private data is in direct opposition of federal regulations prohibiting the dissemination of criminal history and other disqualifying information. The changes outlined in this proposal will eliminate the requirement for an individual to share their disqualification letter and, when applicable, the reason a set aside or variance was granted, thus bringing state statute in compliance with BCA, FBI, and other federal regulatory rules. These changes will mitigate future risk of audit findings related to data sharing and protects an individual's non-public data.

In addition, this proposal will require individuals to access notices and letters related to their study electronically via the NETStudy 2.0 applicant portal. Accessing background studies documentation electronically will streamline the notification process for background study subjects. Challenges with paper notifications impact a person's ability to meet the deadlines for requesting an appeal; this proposal will eliminate the concerns around mailing dates, incorrect addresses, and undeliverable mail. It is anticipated this change will result in cost savings of approximately $500 thousand per year for the agency as it eliminates the need to print and mail background studies documentation. Individuals will retain the option to receive documentation via mail, though electronic delivery will be the primary notification source for background studies documentation.

This proposal will also plan for the development of an electronic process for requesting reconsiderations and appealing a disqualification determination on a background study. It is anticipated that this change, once implemented, will significantly improve a person's ability to meet the deadlines to request reconsideration of a disqualification and streamline the reconsideration and appeals process for individuals. It will also allow DHS to better track data related to background study and request for reconsideration processes.

Proposal:

This proposal has four main components:

First, amendments to chapter 245C will remove the requirement for individuals to share their disqualification letter as well as any disqualifying information in a set aside or variance letter with providers. These changes will bring chapter 245C into compliance with FBI and federal program regulations and will take effect October 1, 2023. A project team will be convened to make the necessary changes to the AEM letters currently sent to individuals and providers.

Second, these amendments will require individuals who are the subject of a background study to receive background study related documents electronically in the NETStudy 2.0 applicant portal. Individuals will maintain the ability to request paper documentation of their background studies. This change will eliminate a significant amount of returned mail due to incorrect addresses and increase an individual's ability to meet the time sensitive deadlines for submitting reconsideration requests, if applicable. The process to begin planning and implementation of system changes will take effect upon legislative approval. Steps for implementation include programming changes in NETStudy 2.0 to create the workflows to trigger electronic delivery of documentation, the creation and dissemination of training materials, and the communication of changes to stakeholders. Consideration must be given to ensure electronic processes are compatible with computer and iPhone and android mobile platforms.

Third, this proposal will plan for the development of a systems change to allow individuals who receive a disqualification determination on a background study to request a reconsideration of or appeal a decision via an electronic process. Background Studies Division will need a dedicated staff to act as technical planner and project manager to identify federal Criminal Justice Information Services (CJIS) compliance and data security needs, necessary technical changes for functionality on web and iPhone and android mobile platforms, and timeline for implementing changes. In addition, this staff will engage with stakeholders including providers, Minnesota Department of Health, Minnesota Department of Corrections, and individuals seeking background studies to ensure this systems change to an electronic request of reconsiderations meets current needs and any projected changes in processes are clearly communicated to stakeholders. In addition, this planning will include staff time from OIG Legal Counsel, OIG Data and Analytics Office, and MNIT. The process to begin planning for systems changes will begin July 1, 2024.

Fourth, changes will improve DHS' ability to track data related to reconsiderations and appeals of disqualification determinations by adapting the use of Microsoft Dynamics 365 to manage and maintain up to 11 BGS work processes that occur outside of NETStudy 2.0. Microsoft Dynamics 365 is a business applications platform that combines components of customer relationship management (CRM) and enterprise productivity/artificial intelligence. This system will allow DHS to integrate processes and data tracking for the following: Preponderance of Evidence Review requests, Statutory Comparison Review requests, in and out of state record requests and fee tracking, Child Abuse and Neglect Registry checks (CANR), Licensing Board checks, border state checks, Sex Offender Registry checks, Maltreatment reviews, external letter generation requests and distributions, expungement requests and processing, and contract and interagency agreement compliance tracking. BGS division will need to hire one FTE as a three year, Temporary Unclassified Human Services Representative 1 (MAPE 11) to manage the planning and implementation of this improved system. Work will begin on this process improvement October 1, 2023.

Impact on Children and Families:

The proposal affects the safety and quality of child care and other programs serving children and vulnerable adults and protects the private data of individuals who are the subject of a background study. Eliminating barriers for individuals to appeal a disqualification decision will help to address workforce shortage issues in childcare and other support services fields. This proposal protects the safety and wellbeing of children and vulnerable adults while contributing to the availability of an appropriately vetted workforce for providers serving these vulnerable populations.

Equity and Inclusion:

This proposal supports Minnesota's workforce needs by reducing barriers for meeting the timeline to request a reconsideration of a background study. It also protects the private information of an individual who may have disqualifying events in their backgrounds but do not pose a risk to others; eliminating the requirement to share those details with a prospective employer could result in an individual considering employment opportunities they may have not pursued in the past.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
This proposal does not have an impact on county finances or operations.

Results:
Disqualification data sharing: the department maintains data related to the number of disqualifications that occur as a result of a background study. The department also maintains data related to the number of set-asides or variances that are requested and granted.

Type of Measure	*Name of Measure*	*2018*	*2019*
Quantity	Disqualifying determinations	7,622	12,928
Quantity	Set asides granted*	1,957	2,507
Quantity	Variances granted	146	185

*Includes the following reconsideration outcomes: previous set aside, remains set aside, set aside, and limited set aside

- *Previous set aside: the previously issued set aside for an individual is applied to a new study for the same individual where the provider is of a similar type to the previous set aside, and there is no new information that indicates the individual may pose a risk of harm.*
- *Remains set aside: the previously issued set aside for an individual is applied to a new study from the same provider if there is no new information that indicates the individual may pose a risk of harm.*
- *Set aside: a risk of harm review found that a disqualified individual provided sufficient evidence to demonstrate they do not pose a risk of harm to any person served by the program, so they are able to provide services without restriction.*
- *Limited set aside: a risk of harm review found that the disqualified individual provided sufficient evidence to demonstrate they do not pose a risk of harm to a specific person receiving personal care assistance services. A limited set aside is only available for personal care provider organizations under Minn. Stat. sec. 245C.22, subd. 5(a).*

Electronic access to background studies documents: Track the number of available notifications in the NETStudy 2.0 applicant portal. Compare the number of reconsideration requests before and after system changes implemented.

IT Costs:
In order to make necessary systems changes to AEM notification letters as part of this proposal, MNIT estimates 524 hours of work over approximately three months. In addition, the systems changes for AEM will result in increased ongoing maintenance and operations costs estimated at 20 percent of the total initial development cost.

For Microsoft Dynamics 365 CRM changes, MNIT estimates 1,964 hours of work over approximately four months along with ongoing maintenance and operations costs estimated at 20 percent of the total initial development cost.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			409	269	678	269	157	426
HCAF								
Federal TANF								
Other Fund								
Total All Funds			**409**	**269**	**678**	**269**	**157**	**426**
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	11	OIG FTEs (Background Studies, Legal, and Data and Analytics) (2,2,2,1)	285	332	617	332	168	499
GF	11	NETStudy 2.0 System Modification (P/T Contract)	60	0	60	0	0	0
GF	11	MNIT Admin Costs (NETStudy 2.0 Operations)	0	12	12	12	12	24
GF	11	MNIT Admin Costs (AEM Changes)	52	10	62	10	10	20
GF	11	MNIT Admin Costs (CRM)	204	41	245	41	41	82
GF	REV	Admin FFP @ 32%	(192)	(126)	(318)	(126)	(74)	(200)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
			2	2		2	1	

Statutory Change(s):

245C.02, Subd. 13e
245C.05, Subd. 1, Subd. 2c, Subd. 4
245C.17, Subd. 2; 245C.17, Subd. 3
245C.22, Subd. 7
245C.23, Subd. 1
13.46, Subd. 4

Change Item Title: Census Income Exclusion for Benefits

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Department of Administration				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Department of Human Services				
Expenditures	66	13	13	13
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	66	13	13	13
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends additional funding of $66,000 in FY 2024 and $13,000 in FY 2025 and each subsequent year from the general fund to exclude income earned as decennial census workers from state calculations for certain benefits.

Rationale/Background:

The State Demographic Center (SDC) at the Department of Administration (Admin) serves as an official liaison to the U.S. Census Bureau and plays a lead role in coordinating Minnesota's decennial census response.

Minnesota was at risk of losing a congressional seat and significant federal funding based on its population count in the 2020 census. Thanks to efforts by census enumerators, Minnesota was able to retain all eight congressional seats by the close margin of fewer than 100 people.

The recruitment of census enumerators from historically undercounted areas is especially important to an accurate census count in low-income Minnesota communities. This is because enumerators play an important role in building trust and encouraging residents to participate in the census. Allowing this exclusion, as many states have already done, would assist with staff recruitment and retention for the next census in Minnesota. According to the National Council of State Legislatures, most states exclude census income from some public benefits to help aid with recruitment of census takers including Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, and West Virginia.

Proposal:

Exclude income earned as decennial census workers from state calculations for Minnesota's economic assistance programs. Specifically, Minnesota Family Investment Program (MFIP), Diversionary Work Program (DWP), Child Care Assistance Program (CCAP), General Assistance (GA), and Minnesota Supplemental Aid (MSA) benefits.

To implement this change, the Governor recommends $66,000 in FY 2024 and $13,000 in FY 2025 and each subsequent year for the Department of Human Services to cover related IT costs.

Impact on Children and Families:
Young children are among the groups that are historically undercounted by censuses. In 2020, three percent of U.S. children under the age of five were estimated to have been missed. An accurate count of children is important because the census guides the distribution of funding to programs that are aimed at supporting vulnerable children and families. Without a complete count, federal and state funds may not reach the groups they are intended to help.

Equity and Inclusion:
Finding people to fill census jobs was among the most difficult obstacles during the 2020 Census. Increasing the pool of applicants in low-income and BIPOC communities by incentivizing program recipients to work as enumerators would increase the pool of potential census takers working in low-wealth and culturally diverse communities, groups that are also historically undercounted in censuses. An accurate count of historically undercounted groups is important to ensure that future political representation and funding is fairly extended to diverse and low-wealth communities.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll						
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)	66	13	13	13	13	13
Total	**66**	**13**	**13**	**13**	**13**	**13**
MNIT FTEs						
Agency FTEs						

Results:
This proposal will support the next census in Minnesota and is expected to result in higher response rates from low-income and BIPOC communities.

Statutory Change(s):
256P.01, 256P.02, and 256P.06

Change Item Title: Easy Enrollment

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures – MNsure	70	70	70	70
Expenditures – Dept. of Revenue	40	4	4	4
Expenditures – Human Services	343	394	394	394
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	453	468	468	468
FTEs	**2.2**	**2.2**	**2.2**	**2.2**

Recommendation:

The Governor recommends establishing an "Easy Enrollment" program to reduce the number of uninsured Minnesotans and increase access to affordable health insurance coverage. Uninsured individuals and families will have the option to check a box on their annual income taxes filed with the Minnesota Department of Revenue (the Department) and be connected to the state's health insurance exchange (MNsure) for access to no- or low-cost health insurance. This proposal requires an investment in the FY2024-25 biennium of $876 thousand from the general fund and $936 thousand from the general fund in the FY2026-27 biennium. Costs for the Department of Revenue and the Department of Human Services are included in this proposal.

Rationale/Background:

Minnesota has long been a leader in health care policies and programs that expand access to health insurance coverage and Minnesota consistently ranks among the top states for low rates of uninsurance. According to the Minnesota Department of Health (MDH), the uninsurance rate in Minnesota in 2021 was four percent, the lowest rate the survey has recorded[1]. However, four percent means about 230,000 Minnesotans continue to lack the security and peace-of-mind of affordable health insurance coverage, and uninsurance rates remain stubbornly high for communities of color and indigenous communities. This is unacceptable.

According to the last two consecutive Health Access Surveys from the MDH, as many as 75% or more of uninsured Minnesotans may be eligible, based on their income, for programs that would make their health insurance more affordable. This includes Medical Assistance, MinnesotaCare, or federal premium tax credits and cost-sharing reductions available on private insurance plans sold through MNsure.

Determining exactly why some Minnesotans remain uninsured has historically been a complex question. That many uninsured Minnesotans are likely eligible for affordable coverage that already exists suggests awareness of options and simply not knowing where to start could be key barriers.

[1] Chartbook Section 6: Uninsurance and the Safety Net (state.mn.us)

While MNsure manages ongoing strategic statewide awareness campaigns designed to reach Minnesotans in need of affordable health insurance, and our statewide network of certified navigators and brokers undertake their own outreach efforts in their communities, these outreach methods are oftentimes more generalized public awareness communications to reach a broad audience of people. A more targeted approach would amplify these efforts and allow MNsure to directly reach people who have self-identified as in need of information about health insurance options.

An Easy Enrollment program is a simple and cost-effective way for the state to increase health insurance rates. The program is designed to help those who are uninsured easily and voluntarily request help accessing affordable health insurance coverage. The program leverages an existing touch point between the person and the state enterprise: the annual income tax filing process. The tax filer authorizes the Department of Revenue to share relevant information from their income tax forms with MNsure in order to assess their projected eligibility for financial assistance and coverage options. MNsure would conduct targeted outreach to each participating household that includes their potential eligibility and information on how to enroll.

A voluntary, opt-in Easy Enrollment program would meet uninsured Minnesotans where they are at, by making it simple and easy to request information about their potential eligibility for financial assistance to lower the cost of their health insurance, giving them concrete details about their coverage options and specific information about how to apply and enroll. The program also reduces the level of effort and resources it would otherwise take to identify and reach them.

Proposal:

The proposal establishes an Easy Enrollment program at MNsure and the Minnesota Department of Revenue. Any Minnesotan who files state income taxes would see a simple box to check on their income tax form indicating they or a member of their tax household are currently without health insurance and they authorize the Department to share their information with MNsure to determine their potential eligibility for insurance coverage and for MNsure to contact them with the results.

The Department would share the appropriate information – like adjusted gross income, tax household size, and taxpayer address-with MNsure in a secure format and MNsure would complete a preliminary eligibility determination for the household. MNsure would then send a letter to the household indicating what they might be eligible for and providing information on application and enrollment assistance, including connecting with a navigator or broker near them for free enrollment assistance.

After completing the application, households that qualify for private coverage through MNsure would qualify for a special enrollment period that permits the household to enroll if outside the open enrollment period. Minnesotans who qualify for public program coverage are already able to enroll at any time during the year once they are determined eligible.

Analyzing Easy Enroll program data available from Maryland, which has a similar state population and total number of estimated uninsured, MNsure assumes Minnesota's experience will be similar to Maryland.[1] MNsure estimates 60,000 households will check the box on their tax forms and approximately 5,000 people could ultimately gain coverage each year. MNsure could see an estimated 1,500 new enrollments each year and the Minnesota Department of Human Services could see an increase of over 3,500 enrollments in Medical Assistance and MinnesotaCare each year.

The program would be fully implemented by the beginning of calendar year 2025 for tax year 2024 filings.

MNsure estimates $25 thousand in staffing costs each year for receiving data and processing preliminary eligibility determinations and increased calls to MNsure's contact center about the program; as well as $45 thousand for sending notices to participating households each year.

The Department of Revenue estimates $40 thousand in the first year for IT costs for development of a secure database or virtual room and costs for form and instruction changes, including $4,000 ongoing for maintenance and updates.

The Department of Human Services (DHS) estimates $505 thousand in the first fiscal year for two health care access staff, and a federal reimbursement of $162 thousand. In each subsequent fiscal year, DHS estimates $579 thousand for two health care access staff, and a federal reimbursement of $185 thousand.

Impact on Children and Families:
This proposal will increase access to affordable health insurance coverage to more children and families, increasing their ability to seek medical care when it is needed and reducing the risk of medical debt that comes from being uninsured.

Equity and Inclusion:
Minnesotans of color have disproportionately higher rates of uninsurance. This proposal is designed to provide direct outreach to the uninsured population to connect them with affordable coverage options, which will reduce the number of Minnesotans who are uninsured, including Minnesotans of color and Indigenous Minnesotans.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll						
Professional/Technical Contracts	40	4	4	4	4	4
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)						
Total						
MNIT FTEs						
Agency FTEs						

Results:
The Department will be able to track the success of the program through the number of tax filers who check the box. MNsure will be able to assess the desired impact of the program by tracking the exact number of households that use the special enrollment period to enroll into coverage and the uninsured rate after the program goes into effect.

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (with)*	*Date*
Quantity	Boxes checked	-	-	60,000	2025
Quantity	New enrollments (QHP, MA, MCRE)	-	-	5,000	2025
Results	Uninsured Rate	4.0%	2021	3.8%	2026

Statutory Change(s):

MNsure anticipates a possible change to MN Stat. Ch. 62V for a special enrollment period.

Revenue anticipates a potential change to the tax disclosure statute (Minn. Stat. Ch. 270B) to allow sharing of taxpayer data for the purpose of determining eligibility for subsidized health insurance.

Change Item Title: Nursing Home Workforce Standards Board

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures				
DLI	641	322	369	369
DHS				69
Revenues				
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	641	322	369	438
FTEs	**2.0**	**2.0**	**2.0**	**2.0**

Recommendation:

The Governor proposes establishing a Nursing Home Workforce Standards Board responsible for setting minimum standards necessary and appropriate to protect the health and welfare of nursing home workers. The Department of Labor and Industry recommends $641,000 in FY 2024 and $322,000 in FY 2025 for leadership positions to perform work for the Nursing Home Workforce Standards Board and for rulemaking costs. A base appropriation of $369,000 would fund 2.0 FTE ongoing. This proposal also includes $69,000 in FY 2027 at the Department of Human Services.

Rationale/Background:

Minnesota nursing facilities provide vital care for the some of the most vulnerable people in the state. Ensuring nursing home workers have a voice in their conditions of their employment through participation in a Nursing Home Workforce Standards Board alongside employers will improve job quality and better protect vulnerable Minnesotans.

Proposal:

The newly created Nursing Home Workforce Standards Board would include equal numbers of nursing home workers and employers appointed by the Governor, along with commissioners from MN Department of Human Services (DHS), MN Department of Health (MDH), and the MN Department of Labor & Industry (DLI) and would be responsible for investigating wage, benefit, and working conditions of nursing home workers for specific geographic areas of the state and specific nursing home occupations. The board would adopt rules establishing minimum standards that are necessary and appropriate to protect the health and welfare of nursing home workers, to properly train them and to fully inform them of their rights. The rules would include standards on compensation, working hours, and other working conditions for nursing home workers. The standards set in the rulemaking could be set statewide, to a specific nursing home occupation, to a specific geographic area in the state, or any combination thereof. The Board would certify worker organizations to train nursing home workers on their rights in languages in which the employees are proficient.

The Department of Labor and Industry would have the authority to investigate possible violations and enforce compliance with the minimum nursing home employment standards established by the board. A worker could also bring a civil action in district court.

Impact on Children and Families:
A nursing home standards board with equal representation between workers and employers will level standards, improve working conditions, and better serve the vulnerable Minnesotans being cared for in these facilities. Improved working conditions, wages, and benefits in this low-wage industry will reduce turnover and maintain continuity of care for nursing home residents. Employees will be able to better support themselves and their families.

Equity and Inclusion:
Level standards across the nursing home industry supports low-wage workers and can help close racial and gender pay gaps. Better wages and working conditions can reduce opportunities for discrimination. Empowering workers to better understand and exercise their rights and have a voice in their conditions of employment will promote compliance and support workers and the vulnerable Minnesotans in their care.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs
N/A

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Impact*	*Date*
Quantity	Improved education and enforcement	N/A	N/A	100% of nursing home employees impacted by standards trained by a certified worker organization	FY25
Quantity	Improved employee retention	N/A	N/A	Reduced turnover	FY25
Quantity	Improved workplace safety	N/A	N/A	50% reduction in workplace injuries	FY25

Statutory Change(s):
Minn. Stat. § 177.27, Minn. Stat. § 181

Change Item Title: Technology Modernization

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures – MNsure	$12,621	$12,351	$3,521	$0
Expenditures – DHS	$1,596	$1,625	$935	$1,029
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	$14,217	$13,976	$4,456	$1,029
FTEs	**6**	**6**	**4**	**0**

Recommendation:

The Governor recommends investing $30.457 million to upgrade and replace the core technology that supports MNsure, the Minnesota Health Insurance Marketplace, and the Minnesotans who use the technology to shop and enroll in a Qualified Health Plan (QHP). Modernization would introduce self-service functionality for consumers to access and update their account information, replace eligibility determination for consumers who are shopping for a QHP while preserving the existing "No Wrong Door" approach to applying for health coverage across state programs, introduce a fully-integrated portal for navigators and brokers who assist QHP applicants, and upgrade the systems caseworkers use to access, maintain, and update consumer accounts. Costs for the Department of Human Services are included in this proposal.

Rationale/Background:

MNsure was established on March 20, 2013 to promote consumer choice, reduce health disparities, simplify enrollment in QHPs, and facilitate transitions in coverage between QHPs and public health care programs. The Minnesota Eligibility Technology System (METS) is the online IT system used by MNsure, the Department of Human Services (DHS) and counties, and serves as a centralized resource for individuals to apply for public health care programs and explore private health insurance options. This web-based enrollment system opened in October 2013.

MNsure has worked with state agency partners to upgrade the platform and improve service delivery for Minnesotans since our launch. However, structural limitations in the aging technology limit improvements to those that are incremental, often expensive, and hinder efforts necessary for creating a modern application and enrollment experience.

MNsure addressed some of these limitations in 2019 by replacing the enrollment portion of the legacy technology. New functionality was introduced that allowed individuals to compare, shop, and enroll in QHPs. At the same time, it enabled MNsure to better manage and report consumer enrollment information and to interface with insurance carriers' and federal entities' systems. The result has been substantial improvements to MNsure operations and significant service improvements for consumers.

The value of the 2019 technology investment became more evident when MNsure was able to leverage the new technology and rapidly implement program changes mandated by the American Rescue Plan Act of 2021. By modernizing the remaining legacy components of the IT platform, MNsure will be better poised to support new or revised regulations and policies affecting the state exchange, and to provide the flexibility to support healthcare policy innovation quickly and more cost effectively.

MNsure has also responded to the structural limitations in the legacy technology with higher staffing levels and increased manual work; but these measures are costly, inefficient, and cannot address the constraints Minnesotans who access the system are experiencing.

Upgrading and replacing outdated legacy technology will not only improve the consumer experience, it will result in a meaningful reduction of MNsure's operating costs. Expenditures that benefit both public and private program enrollees are allocated between MNsure and DHS in accordance with the Public Assistance Cost Allocation Plan (PACAP). The PACAP describes how the agencies allocate these expenditures, using metrics such as program enrollment and contact center utilization. The reduction to MNsure's operations costs resulting from this IT project would result in annual savings to DHS through the PACAP formula.

Public Input:
This proposal addresses feedback from multiple stakeholders. Stakeholders cited easier access for consumers and navigators to view and update critical information related to eligibility and enrollment, more efficient processing of life event changes, and enhanced capabilities for serving Minnesotans with limited English proficiency as critical factors in removing barriers to access to health insurance coverage. All of these stakeholder priorities are directly addressed by the new functionality in the proposal described in further detail below.

Proposal:

The Governor recommends developing and launching new technology that would: support consumers in completing and submitting QHP applications; support certified navigators and brokers who assist consumers in submitting an application and enrolling in coverage; verify consumers' income and identities with the federal data hub; determine eligibility and calculate APTC and cost-sharing reductions (CSR, also known as cost-sharing subsidies); produce eligibility notices; and add case and caseworker management functions. The technology upgrades in this proposal would replace the current legacy eligibility technology used to support QHP consumers and programs.

This proposal preserves the existing "No Wrong Door" approach as envisioned by the Affordable Care Act and complies with Minnesota Statutes 2020, section 62V.03, subdivision 1 by integrating new and legacy technologies to facilitate continuous coverage for individuals transitioning between public health care programs and QHPs. Utilizing IT interoperability for a streamlined consumer application experience, Minnesotans can apply for health coverage without having to specify the program they are applying for or needing to navigate multiple agencies and systems. Applicants would be enrolled in the most beneficial program for which they are eligible, and caseworkers would have access to the data needed for assisting consumers through the application and renewal processes.

Upgrading and replacing legacy eligibility technology supports MNsure's efforts to improve the service levels provided to QHP members, establish more sustainable operations, and update the platform with modular and scalable technology that is easily upgradable, has lower maintenance and operations costs, and has the flexibility to support future federal and state healthcare policy innovation.

Key Features of This Proposal:

- 60% of MNsure's IT costs are attributable to keeping METS' legacy technology operational. These costs increase each year, taking a larger share of MNsure's budget without delivering discernable improvements to QHP consumers or caseworkers. While METS governance is shared between MNsure, DHS, County and Tribal agencies, MNsure has very limited ability to prioritize fixes or enhancements that are important for QHP programs and consumers. This technology modernization proposal would give MNsure more control over its limited resources and the flexibility to be more responsive to market and consumer needs. Improving MNsure's ability to remain sustainable would preserve the programmatic activities that help MNsure fulfill its mission.
- MNsure spends more than $4 million annually in contact center and operations costs to compensate for gaps in IT functionality and the resulting inefficiencies. Operational work, such as life events, are a pain point for consumers and assisters as they report the change to the contact center, wait for the changes to be manually processed, and wait again for their eligibility determination to become effective. Data from FY21 confirms that modernizing technology used by caseworkers would reduce MNsure's dependence on manual operations work, resulting in a workload reduction of almost 34,000 staff hours.
- This proposal would introduce self-service capabilities allowing consumers to access and update their account information, remove information when it becomes outdated, and answer common questions without the assistance of a customer service agent. An analysis of FY21 data suggests self-service capabilities would have reduced the most common calls to the contact center by 55%, from about 285,000 calls per year to about 128,000. Tickets for manual work associated with life event changes would decline 66%, from about 73,000 manually-processed tickets to 25,000. Combined, these two categories represent a potential reduction in customer-facing interactions of more than 33,000 consumer and staff hours.
- Assisters will benefit from a dedicated portal that allows them to enter, review and update information on behalf of the Minnesotans seeking the security of health insurance coverage. With modernized technology, they will be able to report life event changes directly to the system, significantly reducing delays in eligibility determination and ensuring individuals and families are receiving the benefits for which they are eligible. Brokers would have improved ability to track their client list and ensure accurate Agent of Record processing.
- The design and architecture of the legacy platform make it prohibitively expensive to implement changes or enhancements. The proposal will introduce technology that can be expanded and built upon to meet business needs, implement federal or state regulatory changes and support health care policy innovation.

Integration between replacement and legacy systems, or any other future system designed for public program applicants, would ensure the best experience for Minnesotans applying for and enrolling in a QHP while allowing DHS and county caseworkers to continue enrolling new members in public programs and managing existing cases without disruption.

- Legacy technology within METS or another future eligibility system would continue operations in support of public programs: completing and submitting health insurance applications, verifying income and identity with the federal data hub, determining eligibility for public programs, and managing the cases of those who are enrolled in public programs.
- Interface functionality that currently exists to share information between METS' legacy enrollment and eligibility platform and MNsure's enrollment system would be expanded to support bi-directional transfers of application information, eligibility determinations, case updates, and other data. This would ensure continued integration and transition of individuals' information between enrollment systems to facilitate continuous coverage for those individuals in public health care programs and QHPs.

Fiscal Detail

MNIT costs to decommission QHP programs from the legacy METS system account for the majority of expected expenses. MNIT has outlined a two-year project that would remove the QHP application process, QHP eligibility determination, notices and QHP caseworker case and consumer management functions. MNIT has also projected annual maintenance and operations (M&O) costs for ongoing system support. With funding, the work could begin in July 2023 and complete in June 2025, prior to the open enrollment period for plan year 2026.

MNsure would license replacement eligibility, caseworker, assister and other technology from an outside vendor. Replacement costs have been estimated using estimates MNsure has received and have been compared with information from other state exchanges who have completed comparable IT modernization projects. Design, development, and integration (DDI) of replacement technology will take place in parallel with MNIT development work. Vendor work to deliver the replacement IT would complete in June 2025, prior to the open enrollment period for plan year 2026.

Fiscal Detail	FY 2024	FY 2025	FY 2026	FY 2027
METS Costs, incl. Decommission and Year One M&O	$8,815	$8,816	$521	
New Eligibility License, DDI, and Year One M&O	$1,890	$1,610	$3,000	
Temporary Personnel	$320	$300		
Total	$11,025	$10,726	$3,521	

IT modernization would introduce operational efficiencies that produce material savings. Support for consumer self-service, a corresponding reduction in telephone calls and manually-processed life event changes and improved caseworker technology would eliminate the dependence on increased staffing levels to compensate for IT gaps and inefficiencies. We cannot estimate potential savings in FY26 during the transition period moving from the legacy technology to the new system, but we estimate permanent annual savings to the state of over $4 million beginning July 2026. We also expect other management, operations, training, and system support savings will manifest as MNsure updates policies and practices once the system deploys. The proposal includes a temporary FTE increase to support project planning and deployment.

MNsure FTE Detail	FY 2024	FY 2025	FY 2026	FY 2027
1 Temporary BA	$200	$200		
1 Temporary QA	$100	$100		
Other	$20			
Total ($000s)	**$320**	**$300**		
FTE	**2**	**2**		

Decommissioning QHP programs from METS will reduce MNsure's responsibility for some METS costs. MNsure currently pays a percentage of METS operations charges, and while MNsure will continue funding some enterprise activities, IT modernization will result in an estimated $1.5 million reduction in MNsure's funding of METS beginning in FY27.

The Department of Human Services estimates $3.221 million in the first biennium and $1.964 million in the second biennium for costs associated with MNsure's IT modernization proposal. These costs cover temporary staffing and other business resources to assist with system design and implementation, and funding to replace lost revenue to DHS related to ongoing METS sustainability.

Impact on Children and Families:

Since October 2013, when QHP enrollments were first opened to Minnesotans through the State's online marketplace, MNsure has processed almost 1.1 million QHP signups for health insurance coverage and administered over $1.6 billion in federal APTC. For the current 2022 plan year, over 150,000 Minnesotans have signed up for coverage in a QHP, and MNsure is on track to make more than $275 million in premium reductions available to qualifying Minnesotans. These savings lower the cost of monthly insurance payments and provide immediate assistance to those who qualify.

This proposal improves the consumer experience by making it possible for consumers to self-report and maintain their account and other information without having to phone the contact center for assistance. Increasingly, self-service support is becoming the medium of choice for consumers, in part because it saves time and is more convenient. Self-service would deliver much more than just savings in time and cost. Introducing self-service would improve consumer satisfaction and strengthen the relationship between MNsure and consumers, increasing the likelihood of consumers retaining their health coverage.

Equity and Inclusion:

MNsure's mission is to ensure all Minnesotans have the security of health insurance. MNsure serves individuals and families in Minnesota who are:

- Uninsured or underinsured
- Buying health coverage on their own
- Seeking a better option
- Qualifying for Medical Assistance (MA)
- Applying for and receiving MinnesotaCare

Some Minnesotans face barriers while navigating the health care system. We know that individuals with limited English proficiency (LEP) too often encounter linguistic barriers when seeking health care and coverage, and the consequences can be dire for these individuals and their families. LEP is a key barrier to health care and is associated with poorer health status in non-white racial/ethnic groups who are more likely to be uninsured. Though the uninsured rate in Minnesota is 4%, that figure is significantly higher for communities of color. Minnesotans born outside the U.S. have an uninsured rate of 20% and, in the Twin Cities metro area, people of color account for nearly 70% of the underinsured/uninsured population.

The IT upgrades proposed in this request will allow MNsure to publish the online health insurance application in multiple languages, in addition to English, thereby removing a significant accessibility barrier. With upgraded technology, Minnesotans will more easily find and enroll in comprehensive health coverage. Offering the application and enrollment experience in more languages will be a significant benefit to Minnesotans who speak another language with LEP, meaning more Minnesotans' will be able to obtain health coverage on the state's marketplace.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs

This is an infrastructure investment that will decommission QHP program support from METS legacy technology, and extend interfaces to support bi-directional transfer of application, eligibility, case updates and other data between state systems and the replacement technology. MNIT estimated costs to decommission QHP from METS in November 2022. The cost of replacement technology is based on estimates MNsure has received and has been compared with other state exchanges who have completed comparable IT modernization projects.

Category	*FY 2024*	*FY 2025*	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll						
Professional/Technical Contracts	$320	$300				
Infrastructure						
Hardware						
Software	$1,890	$1,610	$3,000			
Training						
Enterprise Services						
Staff costs (MNIT or agency)	$8,815	$8,816	$521			
Total	**$11,025**	**$10,726**	**$3,521**			
MNIT FTEs						
Agency FTEs	2	2				

Results:

Modernizing the technology that supports the MNsure exchange will improve the consumer experience by providing self-service functionality and making the process for reporting life event changes and receiving eligibility updates easier and more efficient. Assisters will benefit from a dedicated portal that allows them to report life event and other changes on behalf of their clients. Making the online application available in multiple languages will improve accessibility for Minnesotans with LEP. And fewer calls to the contact center and upgraded caseworker tools will result in permanent annual savings to the state.

Type of Measure	*Name of Measure*	*Current*	*Projected*
Result	Annual CC/Ops Budget	$ 12M	$8M
Quantity	Reduction in CC/Broker line calls	285,000	>30%
Quantity	Reduction in manual LE processing	73,000 tickets	>60%

Fiscal Detail:

Department of Human Services Costs						
Net Impact by Fund (dollars in thousands)			**FY 24**	**FY 25**	**FY 26**	**FY 27**
General Fund			1,596	1,625	935	1,029
HCAF						
Federal TANF						
Other Fund						
Total All Funds			1,596	1,625	935	1,029
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 26**	**FY 27**
GF	13	HCA Admin - FTEs (4,4,4,0)	566	661	661	0
GF	13	HCA Admin - Other	368	354	158	0
GF	REV1	FFP @ 32%	(299)	(325)	(262)	0
GF	11	State Share of Systems Costs (METS)	961	936	379	229
GF	11	METS operational funding replacement				800
		Requested FTE's				
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 26**	**FY 27**
GF	13	HCA Admin - FTEs (4,4,4,0)	4	4	4	0

Statutory Change(s):

N/A

Change Item Title: Paid Family and Medical Leave Insurance

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures				
MMB Non-Operating	0	0	75	5,824
DHS				199
Transfer Out	668,321	0	0	0
GF Net Fiscal Impact =	**668,321**	**0**	**75**	**6,023**
Paid Family Medical Leave Fund				
Expenditures				
DEED	41,659	36,492	64,657	92,640
MMB	0	0	43	44
Commerce	367	316	128	128
DLI	601	480	646	646
DHS	2,649	0	530	530
Supreme Court	0	0	20	0
Legislature	0	0	11	0
Court of Appeals	0	0	0	5,600
Benefits	0	0	0	1,038,531
Transfer In	668,321	0	0	0
Revenues	0	0	0	1,219,808
All Funds Net Fiscal Impact = (Expenditures – Revenues)	**45,276**	**37,288**	**66,110**	**(75,666)**
FTEs	**39.5**	**65.5**	**241.75**	**410.5**

Recommendation:

The Governor recommends $668.321 million from the general fund in FY 2024-25 and $6.098 million in FY 2026-27. The Governor also recommends applying a 0.6% premium rate to employee wages beginning on July 1, 2026, to establish a Paid Family and Medical Leave Insurance program and that employee contributions comprise one-half of the premium rate.

The transfer of $668.321 million from the general fund provides funds necessary to cash flow the program to enable benefit payments to commence simultaneously with tax collections. It will also support the development of an IT system for collecting premiums and paying benefits, initial staffing and administrative resources required to implement and operate this program at the Department of Employment and Economic Development and other state agencies and branches of government.

Rationale/Background:

Most Minnesotans will need Paid Family and Medical Leave at some point in their lives – whether due to illness, a new child, or family caretaking. But today, approximately 26 percent of all family and medical leaves do not include any wage replacement. According to the "Paid Family & Medical Leave Insurance: Options for Designing and Implementing a Minnesota Program" released in February 2016, around 10% of Minnesota workers take a family or medical leave in any given year. Fifty-nine percent (59%) of current leaves in Minnesota are for own-

health reasons (other than pregnancy), 17 percent are for bonding/parental leave (including pregnancy disability), and 24 percent of leaves are for caretaking a seriously ill family member.

Low-wage employees, certain minority groups, younger workers, and less educated populations are much more likely to lack access to paid leave. For many low-income Minnesotans, taking leave with little or no pay can create significant economic instability for their families, often during some of the most challenging times. Additionally, Minnesota workers are generally less likely to receive compensation during leave for their own serious health condition or family care than for pregnancy or parental (bonding/maternity/paternity) leave.

Without a comprehensive state paid family and medical leave program, Minnesotans are missing out on the economic stability and economy-boosting effects of keeping people employed while welcoming a new family member, caring for a sick loved one, or recovering from an illness or injury. Paid Family and Medical Leave is a critical tool towards enhancing Minnesota's economic competitiveness and building a more stable and resilient workforce.

Proposal:

The Governor recommends creating a new Minnesota Family and Medical Leave Program administered by DEED. This program will provide wage replacement for family and medical leaves and will provide job protections for recipients, so they are assured of continued employment with their employer upon their return. Premiums collected will fund program benefits and ongoing administrative costs.

Appropriations from the general fund will allocate:

- $519.266 million from the general fund in FY 2024-25 will fund a reserve balance in the Paid Family and Medical Leave (PFML) Fund. This will provide adequate cash flow to permit initiation of benefits simultaneously with the start of premium collections on July 1, 2026.
- An additional transfer of $149.055 million from the general fund in FY 2024-25 will fund start up costs for administration of the program to be appropriated from the PFML Fund.
- $5.899 million in FY 2026-27 will be provided to Minnesota Management and Budget Non-Operating to offset employer-paid premium costs in the general fund for state executive and judicial branch agencies and offset the costs to agencies for obtaining notice acknowledgments from employees.
- $199 thousand in FY 2026-27 for the Department of Human Services for the impact of the paid family medical leave program on Medicaid nursing facility rates.

Proposed appropriations from the new PFML Fund include:

- $78.151 million in FY 2024-25 and $157.297 million in FY 2026-27 for the Department of Employment and Economic Development will support the creation of business process design, a premium collection system, benefits payment system, user interface development, and program administration.
- $87 thousand in FY 2026-27 for Minnesota Management and Budget will fund state executive branch employee workplace notice costs as well as upgrades to the state's payroll system necessary for the collection of premiums.
- $683 thousand in FY 2024-25 and $256 thousand in FY 2026-27 for the Department of Commerce will fund development of private plan rules and approvals.
- $1.081 million in FY 2024-25 and $1.292 million in FY 2026-27 for the Department of Labor and Industry will fund oversight and compliance costs related to the program as well as IT systems upgrades.
- Starting in FY 2027, $5.6 million per year would fund costs related to appeals filed with the Court of Appeals for denied benefit claims.
- $11 thousand in FY 2026-27 for the Legislature-LCC will support onetime payroll system updates.
- $20 thousand in FY 2026-27 for the Supreme Court will support onetime system updates.
- $2.649 million in FY 2024-25 and $1.060 million in FY 2026-27 for the Department of Human Services to make systems modifications necessary for the implementation of the program.

Impact on Children and Families:

Similar programs in other states have shown improvements in economic stability for families and positive impacts for children. Societal benefits include retaining more women in the labor force, reductions in the need and associated costs for nursing home and other institutional care, reductions in the need for public assistance when a new baby arrives, and less infant care shortages.

Equity and Inclusion:

According to the 2016 report, while almost three-quarters of Minnesota workers received at least some pay when they were out of work for family or medical reasons, low-wage (46%); black (42%); or Hispanic (39%); younger (39%); part-time (38%) or less educated (38%) workers are much more likely to manage leaves without any pay. This proposal is intended to help address that inequality and the economic impacts that that inequality has on these workers.

IT Related Proposals:

This recommendation includes funding for IT costs to create a system for collecting premiums from employers and paying program benefits to recipients. The development of the Paid Family and Medical Leave system will be a multi-year project. The total cost to build the system between FY 2024 and FY 2028 is anticipated to be approximately $80.4 million, plus approximately $6.0 million in staff costs.

Results:

Department of Employment and Economic Development will track the following:

- Amount of leave taken
- Amount of benefit payments made to recipients
- Employer opt-outs
- Employee opt-ins
- Program tax collections and balance
- Customer satisfaction

Change Item Title: Legalizing Adult-Use Cannabis

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Cannabis Management Office Expenditures	$15,430	$14,841	$13,980	$13,711
DEED Expenditures	$10,400	$6,700	$0	$0
Health Expenditures	$8,115	$8,115	$8,115	$8,115
Public Safety Expenditures	$4,175	$2,662	$2,662	$2,662
Revenue Expenditures	$3,673	$3,118	$3,138	$3,153
Human Services Expenditures	$2,260	$6,476	$6,476	$6,476
Cannabis Expungement Board Expenditures	$921	$844	$844	$844
Pollution Control Expenditures	$607	$496	$70	$70
Supreme Court Expenditures	$545	$545	$0	$0
Higher Education Expenditures	$500	$500	$500	$500
Agriculture Expenditures	$411	$411	$338	$338
Natural Resources Expenditures	$338	$0	$0	$0
Education Expenditures	$180	$120	$120	$120
Labor and Industry Expenditures	$132	$132	$132	$132
Commerce Expenditures	$75	$283	$569	$799
Corrections Expenditures	($177)	($345)	($407)	($458)
Tax Aids, Credits, and Refunds Revenues	$5,800	$31,000	$79,300	$130,800
Cannabis Management Office Revenues	$1,996	$3,330	$4,000	$6,000
State Government Special Revenue Fund				
Health Expenditures	($3,424)	($3,424)	($3,424)	($3,424)
Health Revenues	($7,411)	($10,879)	($12,973)	($19,223)
Trunk Highway Fund				
Public Safety Expenditures	$5,608	$1,668	$1,668	$1,668
Outdoor Heritage Fund				
Tax Aids, Credits, and Refunds Revenues	($3)	$96	$330	$594
Arts and Cultural Heritage Fund				
Tax Aids, Credits, and Refunds Revenues	($2)	$57	$198	$356
Clean Water Fund				
Tax Aids, Credits, and Refunds Revenues	($3)	$96	$330	$594
Parks and Trails Fund				
Tax Aids, Credits, and Refunds Revenues	($1)	$41	$142	$257
Net Fiscal Impact = (Expenditures – Revenues)	$49,393	$19,401	($36,546)	($84,672)
FTEs	**92**	**98**	**104**	**104**

Recommendation:

The Governor recommends funding for the safe and responsible legalization of cannabis for adults in Minnesota. A new Cannabis Management Office will be responsible for the implementation of the regulatory framework for adult-use cannabis, along with the medical cannabis program, and a program to regulate hemp and hemp-derived products. This recommendation also includes funding for grants to assist individuals entering the legal cannabis market, provides for expungement of non-violent offenses involving cannabis, and implements taxes on adult-use cannabis.

Rationale/Background:

Prohibiting the use of cannabis in Minnesota has not worked. Despite the current prohibition, marijuana is widely consumed across Minnesota. The most recent Minnesota Survey on Adult Substance Use conducted in 2014-2015 found that nearly half (44%) of Minnesota adults reported using marijuana at some point during their lives. The maturation of the market for hemp-derived cannabinoid products following the 2018 Farm Bill culminating in the 2022 legislation authorizing hemp-derived THC edible cannabinoids have created urgency for comprehensive regulation and reform at the state level.

Regulating cannabis for use by adults will replace the abundant illicit market with a tightly regulated system with controls similar to those currently accepted for the sale of alcohol. This proposal will allow for the monitoring and regulation of its cultivation, processing, transportation and sale, activities currently occurring to the profit of drug cartels and criminals and without consumer protection guardrails.

Importantly, this proposal will begin to address racial inequities our current system has created. Despite survey data suggesting that Black and white Minnesotans use cannabis at similar rates, in 2021 Black Minnesotans were over four times more likely than their white counterparts to be arrested for marijuana according to data from the Bureau of Criminal Apprehension.

Marijuana prohibition additionally leaves potential tax revenue uncollected and furthers an opportunity for economic growth in the underground market. This proposal will bolster amounts available in the general fund for policymakers to prioritize while grant programs administered by DEED and the Office of Cannabis Management will further ensure Minnesotan entrepreneurs have the best opportunity to become the new adult-use market.

Finally, this approach is now well-tested across the country. Nineteen states and the District of Columbia have passed laws to legalize and regulate cannabis for adults. In Colorado, the first state to adopt this approach, legal sales began in January 2014 so there is now nearly a decade of implementation experience in other states to help craft this proposal for Minnesota.

Proposal:

This proposal creates a new agency, the Cannabis Management Office, which would be responsible for the implementation of a new regulatory framework for adult-use cannabis. The Office of Medical Cannabis will also move from the Department of Health to join this new agency. The office will be headed by a director appointed by the Governor and receive advice from a Cannabis Advisory Council with representatives from experts, local governments, the cannabis industry and relevant state agencies. The core duties of the office will include:

- to develop, maintain, and enforce an organized system of regulation for the lawful cannabis industry
- to establish programming, services, and notification to protect, maintain, and improve the health of citizens.
- to prevent unauthorized access to cannabis by individuals under 21 years of age.
- to establish and regularly update standards for product testing, packaging, and labeling.
- to promote economic growth with an emphasis on growth in areas that experienced a disproportionate, negative impact from cannabis prohibition.
- to issue and renew licenses.
- to impose and collect civil and administrative penalties.
- to authorize research and studies on cannabis, cannabis products, and the cannabis industry.

Adult-use cannabis will be subject to a new 15% gross receipts tax and state sales tax with retail sales beginning January 1, 2025. A new 15% gross receipts tax would also be imposed on the retail sale of edible cannabinoid products with retail sales beginning October 1, 2023.

The proposal authorizes three grant programs to support the establishment of cannabis businesses in Minnesota. Cannabis grower grants administered by the Office of Cannabis Management will provide farmers with assistance navigating the new industry and regulations along with subsidized loans for expanding into legal cannabis.

Administered by the Department of Employment and Economic Development industry navigation grants and industry training grants will assist individuals in setting up a legal cannabis business through technical assistance and navigation services while providing grants to organizations and individuals for training on cannabis jobs.

The proposal provides for automatic sealing of dismissals, exonerations, convictions, or stayed sentences of petty misdemeanor and misdemeanor marijuana offenses by the Bureau of Criminal Apprehension, which will provide notice of the expungement to local law enforcement agencies as well as the Judicial Branch for compliance purposes. It also provides for the establishment of a Cannabis Expungement Board to review other cannabis convictions to consider eligibility for expungement or resentencing.

The proposal authorizes the Governor to enter into compacts with Minnesota Tribal governments on issues related to medical cannabis and adult-use cannabis.

The proposal finally provides significant resources to address substance use disorders. The proposal includes initial funding for grants directed by the advice of a Substance Use Disorder Advisory Council convened by the Department of Human Services. Five percent of the revenue from the cannabis gross receipts tax would flow into this fund to support these grants into the future.

Appropriations necessary for its implementation include:

- $30,271,000 in FY2024/2025 and $27,691,000 in FY2026/2027 to establish and begin operations of a new Cannabis Management Office responsible for the implementation of the new regulatory framework.
- $822,000 in FY2024/2025 and $ 676,000 in FY2026/2027 to the Department of Agriculture for food safety and pesticide enforcement lab testing and rulemaking related to changes in cannabis laws.
- $1,765,000 in FY2024/2025 and $1,688,000 in FY2026/2027 for a newly created Cannabis Expungement Board for staffing and other expenses related to reviewing criminal convictions and issuing decisions related to expungement and resentencing.
- $358,000 in FY2024/2025 and $1,368,000 in FY2026/2027 for the Department of Commerce for staffing and other expenses to complete scale, and packaging inspections.
- A reduction of $522,000 in FY2024/2025 and $865,000 in FY2026/2027 to the Department of Corrections' base budget to account for an expected reduction in marijuana-related incarcerations.
- $300,000 in FY2024/2025 and $240,000 in FY2026/2027 for the Department of Education to support schools and districts in accessing resources on cannabis use and substance use.
- $17,100,000 in FY2024/2025 for the Department of Employment and Economic Development for cannabis industry navigator and startup grants.
- $16,230,000 in FY2024/2025 and $16,230,000 in FY2026/2027 for the Department of Health for education of women who are pregnant, breastfeeding, or who may become pregnant; data collection and reports; and youth education.
- $8,736,000 in FY2024/2025 and $12,952,000 in FY2026/2027 for the Department of Human Services to implement the substance use disorder treatment and prevention grant program and process background studies relevant to the work of the Cannabis Expungement Board.
- $264,000 in FY2024/2025 and $264,000 in FY2026/2027 for the Department of Labor and Industry to identify occupational competency standards and provide technical assistance for developing dual-training programs.
- $338,000 in FY2024/2025 for the Department of Natural Resources for training of DNR Conservation Officers relating to the new cannabis regulatory system and requirements, recognition of impairment, and for the enforcement of the purposed environmental standards adopted by the Cannabis Management Office.
- $1,000,000 in FY2024/2025 and $1,000,000 in FY2026/2027 for the Office of Higher Education for Dual Training Competency Grants to employers in the legal cannabis industry.

- $1,103,000 in FY2024/2025 and $140,000 in FY2026/2027 for the Pollution Control Agency for rulemaking to establish of water, energy, odor, and solid waste environmental standards for cannabis businesses and provide technical assistance for small businesses.
- $6,837,000 in FY2024/2025 and $5,324,000 in FY2026/2027 for the Department of Public Safety Bureau of Criminal Apprehension for identifying and sealing records, forensic science services, and investigations.
- $7,276,000 in FY2024/2025 and $3,336,000 in FY2026/2027 for the Department of Public Safety Minnesota State Patrol from the Trunk Highway Fund for additional Drug Recognition Expert (DRE) troopers, crash reconstruction specialist troopers, and replacement drug detection canines.
- $6,791,000 in FY2024/2025 and $6,291,000 in FY2026/2027 for the Department of Revenue to collect and administer the tax requirements.

Impact on Children and Families:

The current widespread underground market for marijuana provides no controls against the sale and access to children. This proposal provides age restrictions to prevent the sale of cannabis to those under 21. Additionally, the biannual Healthy Kids Colorado Survey found no increase in the use of marijuana from 2011 to 2015 in the period where legal sales initiated in the state, a finding that has been consistent in Washington, Oregon, Alaska, California, Massachusetts, Maine, and Nevada. The proposal additionally provides funding for MDH to conduct a long-term, coordinated education program to raise public awareness about and address adverse health effects associated with the use of cannabis or cannabis products by persons under age 21.

Equity and Inclusion:

This proposal seeks to begin to address the inequities the current system of marijuana prohibition has created, beginning with the expungement of nonviolent marijuana offenses. A Division of Social Equity at the Office of Cannabis Management will work to further promote the consideration of equity and inclusion in the development and implementation of cannabis regulatory systems. The proposal additionally requires the prioritization of social equity applicants in cannabis license selection along with the cannabis grower and industry training and navigation grant programs.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Minnesota tribal governments, in particular the Red Lake Nation and the White Earth Nation, have raised significant concerns about the current interactions between their medical cannabis programs and current restrictions in statute. This proposal will provide broad authority for the Governor or designated representatives to negotiate compacts with an American Indian tribe regulating cannabis and cannabis products including medical cannabis.

Results:

The proposal requires Department of Health to engage in research and data collection activities to measure the prevalence of cannabis use and the use of cannabis products in the state by persons under age 21 and persons age 21 or older.

Statutory Change(s):

13.411, by adding a subdivision; 13.871, by adding a subdivision; 152.02, subdivisions 2, 4; 152.022, subdivisions 1, 2; 152.023, subdivisions 1, 2; 152.024, subdivision 1; 152.025, subdivisions 1, 2; 181.938, subdivision 2; 181.950, subdivisions 2, 4, 5, 8, 13, by adding a subdivision; 181.951, by adding subdivisions; 181.952, by adding a subdivision; 181.953; 181.954; 181.955; 181.957, subdivision 1; 244.05, subdivision 2; 256.01, subdivision 18c; 256D.024, subdivision 1; 256J.26, subdivision 1; 273.13, subdivision 24; 275.025, subdivision 2; 290.0132, subdivision 29; 290.0134, subdivision 19; 297A.67, subdivisions 2, 7; 297A.99, by adding a subdivision; 297D.01, subdivision 2; 297D.04; 297D.06; 297D.07; 297D.08; 297D.085; 297D.09, subdivision 1a; 297D.10; 297D.11; 609.135, subdivision 1; 609.531, subdivision 1; 609.5311, subdivision 1; 609.5314, subdivision 1; 609.5316, subdivision 2; 609.5317, subdivision 1; 609A.01; 609A.03, subdivisions 5, 9; 624.712, by adding subdivisions; 624.713, subdivision 1; 624.714, subdivision 6; 624.7142, subdivision 1; 624.7151; proposing coding for new law in Minnesota Statutes, chapters 3; 17; 28A; 34A; 116J; 116L; 120B; 144; 152; 289A; 295; 604; 609A; 624; proposing coding for new law as Minnesota Statutes, chapter 342; repealing Minnesota Statutes 2020, sections 152.027, subdivisions 3, 4; 152.21; 152.22, subdivisions 1, 2, 3, 4, 5, 5a, 5b, 6, 7, 8, 9, 10, 11, 12, 13, 14; 152.23; 152.24; 152.25, subdivisions 1, 1a, 1b, 1c, 2, 3, 4; 152.26; 152.261; 152.27, subdivisions 1, 2, 3, 4, 5, 6, 7; 152.28, subdivisions 1, 2, 3; 152.29, subdivisions 1, 2, 3, 3a, 4; 152.30; 152.31; 152.32, subdivisions 1, 2, 3; 152.33, 1.38 subdivisions 1, 1a, 2, 3, 4, 5, 6; 152.34; 152.35; 152.36, subdivisions 1, 1a, 2, 3, 4, 5; 152.37; 297D.01, subdivision 1; Minnesota Rules, parts 4770.0100; 4770.0200; 4770.0300; 4770.0400; 4770.0500; 4770.0600; 4770.0800; 4770.0900; 4770.1000; 4770.1100; 4770.1200; 4770.1300; 4770.1400; 4770.1460; 4770.1500; 4770.1600; 4770.1700; 4770.1800; 4770.1900; 4770.2000; 4770.2100; 4770.2200; 4770.2300; 4770.2400; 4770.2700; 4770.2800; 4770.4000; 4770.4002; 4770.4003; 4770.4004; 4770.4005; 4770.4007; 4770.4008; 4770.4009; 4770.4010; 4770.4012; 4770.4013; 4770.4014; 4770.4015; 4770.4016; 4770.4017; 4770.4018; 4770.4030.

Change Item Title: Increase the Health Care Access Fund Appropriation for Medical Assistance

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	0	(897,400)	(63,000)	(522,486)
Revenues	0	0	0	0
Health Care Access Fund				
Expenditures	0	897,400	63,000	522,486
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	**0**	**0**	**0**	**0**

Recommendation:
The Governor recommends one-time increases to the health care access fund appropriation for medical assistance of $897.4 million in FY 2025, $63 million in FY 2026, and $522.5 million in FY 2027.

Rationale/Background:
Medical assistance currently serves around 1.3 million Minnesotans providing health insurance to lower income Minnesotans and Minnesotans with a disability. The medical assistance program is financed primarily through federal and state funds. While medical assistance spending is forecasted, the health care access fund's share is set by the legislature, leaving the remaining state share to be paid by the general fund.

Proposal:
This proposal will increase the health care access fund medical assistance appropriation by $897.4 million in FY 2025, $63 million in fiscal year 2026, and $522.5 million in fiscal year 2027.

Results:
This change will result in increased medical assistance claims being paid by the health care access fund.

Statutory Change(s):
None.

Change Item Title: Acute Care Transitions: Building Statewide Capacity

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	23,522	3,318	4,910	7,250
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	23,522	3,318	4,910	7,250
FTEs	**11.5**	**12.5**	**12.5**	**9**

Recommendation:

The Governor recommends establishing a comprehensive initiative to address the significant problem of people, including children, who are residing in hospitals because appropriate community-based homes and/or services are not available or cannot meet their needs. Hospitals and health systems are struggling to discharge people to appropriate settings, leading to backlogs in hospital in-patient admissions and restricted access to emergency services and restricted access to hospital services overall. This proposal recommends comprehensive, statewide strategies to improve Minnesota's overall capacity to serve people with complex support needs in their communities.

This proposal invests $26.8 million in the FY24-25 biennium and $12.2 million in the FY26-27 biennium.

Rationale/Background:

Hospitals across the nation report that there are significant delays in discharging children and adults with complex, high-acuity support needs to the community. Hospital overcrowding and complications related to disruptive behaviors for both children and adults are having a negative impact on the quality of life for patients and their families. According to a survey conducted by the Minnesota Hospital Association, discharges for approximately 1,984 patients were delayed despite no longer needing a hospital level of care during December 11-17, 2022. The Minnesota Department of Health reports emergency room beds are occupied at an average of 98-100%, far exceeding the public health occupancy standards and significantly impeding Minnesotans' access to life-saving medical care.

The causes for the current acute-care backlog are multi-faceted, impacting people and providers across the acute and long-term care system. Hospitals report that the most common barrier to identifying appropriate discharge locations is the complexity of the support needs presented by the patient, making it more difficult to find long-term services and support providers that can meet the needs of the person in the community. These people are often referred to as "high acuity" patients or people with complex support needs.

People who engage in disruptive behavior, experience psychotic episodes or impulse control or neurological disorders are more likely to revisit the emergency department of hospital. Families, caregivers, and staff often choose hospitalization when the person is a danger to themselves or others because they do not know what to do and are exhausted. Providers often feel that they do not have the training, technical assistance, or resources

to address challenges related to and transitions back into the community. The expense associated with ongoing supports for children and adults with challenging behavior makes it difficult to find solutions for transition planning when people are ready to move back into the community. Research and lived experience demonstrate that using evidence-based positive support practices and a person-centered model of service delivery is an effective approach to ensuring people with complex needs are supported in their communities, maintain their safety, and improve the quality of life (Fixsen et al., 2005; Horner, Sugai, & Fixsen, 2017). This approach can be combined with clinical and medical interventions to create a cohesive support plan that helps the person live the life they want in the community.

Positive supports are approaches that are used to help people using a variety of proven support strategies that do not include punishment or seclusion. Positive supports:

- Build on a person's unique strengths, assets, interests, expectations, cultures, and goals;
- Respect the rights and individuality of each person in the context of their community; and
- Offer solutions that are effective, are used across the lifespan, and often are implemented together.

Positive Supports is a multidimensional approach. Examples of positive support practices include (but are not limited to): positive behavior support, person centered practices, trauma informed supports, motivational interviewing, and dialectical behavior therapy.

Proposal

This proposal provides a statewide strategy to expand provider capacity to support people with complex, high-acuity support needs. This proposal includes short-term and long-term investments to enhance Minnesota's positive support service delivery infrastructure, focusing on improving statewide capacity to transition people from acute care settings and support them in community-based settings.

Time-Limited Premium Payment for High-Acuity Admissions

Supporting people, including children, with complex, high-acuity support needs often requires a provider to incur additional expenses to build administrative and operational capacity quickly and at the organizational level before admitting someone with complex needs. These expenses vary based on the organization, but typical expenses include capital improvements as well as and operational tools to support coordination of care and services, including enhanced focus on creating successful transitions between care settings.

Hospitals categorized as Level 1 and 2 trauma centers report denying admission to patients and re-routing them to other hospitals. Given the public health implications of limited hospital capacity, immediate funding is needed to facilitate discharges quickly so that hospitals regain capacity to meet the emergency medical needs of Minnesotans.

This proposal establishes a temporary state-funded payment program to offset additional provider costs to incentivize admission of a person with complex, high-acuity needs. This payment is available for up to two years so long as the provider can document costs not reimbursed through the typical Medicaid rate for that provider type and subject to available funds.

To be eligible for the state-funded payment, the person being discharged must meet the definition of having complex, high acuity support needs. Complex, high acuity support needs is defined as:

1. Medically complexity that requires highly specialized care coordination and treatment OR
2. Serious aggressive and/or self-harm behavior
   AND

3. Repeated denials of admission to residential settings, service terminations, placement on a waitlist or other inability of providers to properly support the person in a community setting.

Establish an organizational endorsement system to increase provider capacity and competency

People with complex needs require services and supports at multiple provider types. This proposal creates a special endorsement status for an organization/provider that demonstrates competency to deliver positive supports. Organizations that apply and are successfully endorsed will have access to enhanced resources and financial incentives. These resources and incentives will help an organization to support individual people they are serving, as well as build overall organizational capacity to increase staff recruitment and retention.

Resources and incentives include:

- A Consultative Clinical Panel that will include credentialed clinical experts from the following disciplines: positive behavior support, psychology, neuropsychological, psychiatry, occupational therapy, and person-centered planning. The panel will focus on creating the best life possible in these critical situations that are culturally responsive and grounded in evidenced based positive supports. The panel will provide recommendations to support staff to improve positive supports, improve context and environment that meets the individual wants and needs, and improve personal outcomes;
- Enhanced access to current grant programs administered by the Department of Human Services for endorsed organizations;
- Person Centered planning facilitator to help with transition planning from acute care setting; and
- Provider organization positive support training (multi-tiered systems of support) and technical assistance with data collection and evaluation, utilization of implementation science to build multi-tiered system of positive supports within an agency.

For organizations that need more training and support to become endorsed, training and technical assistance will be available to build organizational capacity to apply for endorsement. The training model can be tailored for the specific needs of the provider based on size, current experience delivering positive supports, and the goals of the organization. This capacity building effort will include tracks for providers that serve culturally specific communities.

Supporting Older Adults with High/Complex Behavioral Health Support Needs

Many older adults requiring treatment and care for complex behavioral health conditions face numerous barriers in accessing a higher level of service in the community and often experience unnecessary hospital admissions and/or incarcerations as a result. The Elderly Waiver (EW) program funds home and community-based services for people age 65 and older who require the level of care provided in a nursing facility but choose to reside in the community. People age 65 and older face a unique set of challenges, as the individual budgets available through EW are not sufficient to provide the level of support needed for daily living due for those with complex needs. The lack of sufficient resources for home and community-based services creates a barrier for people 65 and older, who would otherwise be able to successfully live in their communities if a broader range of services, supports, and assistance was available.

Upon federal approval, this proposal expands the EW program by offering an enhanced budget for people who have complex needs, require intensive support to live in the community, and who meet a defined eligibility threshold. This proposal will serve people ready to leave Anoka Metro Regional Treatment Center (AMRTC), Minnesota Security Hospital (MSH), a Community Behavioral Health Hospital (CBHH), or who are hospitalized in the community and on a waiting list for AMRTC. This change is necessary to address the issue that individual budgets available under EW are not currently sufficient to help some people with complex needs remain in their place of residence or transition back to a community setting.

Impact on Children and Families:

Families and children with complex behavior and or mental health needs have increasingly relied on emergency departments (ED) for care. Pediatric mental/behavioral health ED visits are typically repeat visits (Frosch et al., 2011; Cloutier et al., 2017). There are many factors associated with mental/behavioral health ED visits and revisits (Cushing et al., 2022). Families and caregivers often choose hospitalization when the child or adolescent is a danger to themselves or others because they do not know what to do and are exhausted. Improved evidenced-based intervention and support services for children and families is needed to reduce pediatric mental health ED uses and ensure access to appropriate supports for the family. Effective and sustainable implementation of evidence-based supports won't happen without a systemic approach.

There are many children with complex behavioral needs that are stuck in hospitals. This proposal helps increase statewide capacity to leverage different systems of care and provide wrap-around supports, thus increasing the likelihood that the child will remain stable in the out-of-home placement and create a pathway toward family reunification. Building positive support capacity in Minnesota will benefit children and families because it will create more community capacity to support families and align efforts with a focus on outcome evaluation and continuous improvement.

Equity and Inclusion:

This proposal could potentially impact any person with a disability receiving long-term services and supports by reducing the incidence and potential longevity of a hospital stay. According to data from the LTSS Demographic Dashboard, as of January 2021, there were 125,735 Minnesotans receiving LTSS. Of people receiving services, 61% were white and 34% were Black, Indigenous and People of Color. Minnesota's overall population was 79.1% white in the same timeframe.

It is expected that this proposal would particularly target individuals with an Intellectual and Developmental Disability (IDD) with a co-occurring mental health condition. It has been estimated that the rate of mental health conditions for those with IDD is two to three times higher than for the general population. Research findings have varied widely with prevalence rates for co-morbidity of IDD and mental health conditions ranging from 13.9% to 75.2%[1].

Estimates of the frequency of psychiatric disorders and emotional disturbance in this population vary widely. However, many professionals have adopted the estimate that 30%-35% of individuals with Intellectual and Developmental Disabilities have a psychiatric disorder. The full range of psychopathology that exists in the general population also can co-exist in people who have Intellectual and Developmental Disabilities. Communication issues often make it difficult for clinicians to assess individuals with IDD for emotional or psychiatric disorders. Another obstacle is "diagnostic overshadowing," which occurs when a health care professional overlooks or minimizes the signs of psychiatric disturbance and instead attributes those manifestations to the person's developmental disability. This causes barriers to service and supports.

[1] Freeman, R., DePasquale, M., Rotholz, D., Moore, M., Moore, T., & Malbica, A. (2020). How positive behavior support can assist in implementation of Home and Community Based Services (HCBS) [positive behavior support brief]. White paper on positive behavior support in the field of intellectual and developmental disabilities. Association for Positive Behavior Support.

The literature and data in education points to the trend that children of color are disproportionately overrepresented and labeled with disabilities categories. Furthermore, children of color are overrepresented and often labeled with emotional or behavioral disturbances. More often they are referred for special services due to behavioral outburst. This leads to high rates of suspension for children of color and sends them down a track leading to more special services and recommendations for out of home treatments. Families struggle to find the supports they need or have issues accessing appropriate services. As stated previously, people of color are not accessing LTSS services as much as their white counterparts. This could be due to a variety of issues, including having a label of multiple diagnoses, being aggressive or being known as difficult to support. In Minnesota, there may be a lack of providers from diverse backgrounds who have the skills and training to support people with complex needs.

Too many systems of care for people with IDD continue to focus on controlling and managing challenging behaviors without adequate consideration of the potential for underlying mental health or medical conditions as the cause of the behavior or taking cultural considerations in to account. The focus of treatment has historically been developing behavior management plans to promote compliance or the use of medications to control the behaviors. In both cases the treatment is targeting the behavior and not the actual mental health or medical condition making recovery unlikely. Often times in practice we have found that there are large cultural differences in people from diverse backgrounds that are different from the Western majority culture. This can directly impact the interpretation and analysis of a behavior of concern.

Navigating the human services system is already challenging for people with disabilities. But for people of color with disabilities, racial bias and human judgment can make it even more difficult to get the support they need to succeed.

In addition, a growing number of Elderly Waiver (EW) and Alternative Care (AC) participants are people are from BIPOC communities. Between 2016 and 2020, the number of BIPOC participants on EW and AC grew from 26 to 32 percent. All individuals who are served by Elderly Waiver component in this proposal are considered persons with a mental health disability.

Tribal Consultation

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

While this proposal does not have a substantial direct effect on Minnesota Tribal Governments, this proposal may help Tribal members experiencing challenges in finding appropriate community-based or elderly waiver services for people with high behavioral health needs.

Impacts to Counties:

Counties are not directly financially impacted by this proposal, but counties have been communicating to DHS for years that they are looking for a statewide approach to helping people move out of acute care settings and into appropriate community-based services.

This proposal provides counties with additional services and support options as they conduct support and transition planning for people in their counties that have complex and high acuity needs. Temporary payments will provide more discharge and providers options than currently exist for this population, making support planning more effective.

In addition, in their role as a lead agency supporting people on EW, counties have brought forward concerns to DHS over the past few years regarding this service gap. In response to these concerns, DHS recently convened a working group to develop a policy recommendation to fill the identified service gap. Members of the working group include DHS staff, counties, managed care organizations, and NAMI, an advocacy organization that represents people with mental health needs. These key stakeholders helped DHS to identify the highest priority concerns and issues in serving this population, in addition to helping DHS to refine and identify the most appropriate policy solution to address this gap.

IT Costs

This proposal requires systems costs to effectuate the premium payments and the change to Elderly Waiver budgets.

Results

This proposal includes a robust data collection and analysis. Data will be collected at the provider level, regional level, and at the statewide level to determine what interventions and approaches are most effective to accomplish successful acute care transitions and life in the community. Data will also be used to analyze the impact of positive support capacity-building efforts, as well as the impact of different financial incentives on overall system capacity. Sources of data include de-identified information at the person level from the clinical panel, and data produced from Culture of Safety mappings. This proposal uses a continuous quality improvement model to determine recommendations for small- and large-scale changes to existing policy or program structures.

Results measured include:

- Number of people served through premium payments
- Number of providers seeking and attaining endorsement
- Number of providers and workers receiving positive support training
- Length of time people wait in a hospital setting for access to services in the community after hospital-level care is not needed
- Success of transition to community care (quality of life measures, longevity, reduction in reoccurring acute care)

Fiscal Impact

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			23,522	3,318	26,840	4,910	7,250	12,160
HCAF								
Federal TANF								
Other Fund								
Total All Funds			23,522	3,318	26,840	4,910	7,250	12,160
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	52	Other Long Term Care Grants - Premium Pay	21,253	0	21,254	0	0	0
GF	13	HCA Admin - FTEs (2,2,2,2)	283	330	613	330	0	330
GF	11	FOD Admin - FTEs (0.5,0.5,0.5,0.5)	66	77	143	77	0	77
GF	14	ADSA Admin - FTEs (1,1,1,1)	141	165	306	165	0	165
GF	REV1	Admin FFP @ 32%	(157)	(183)	(340)	(183)	0	(183)
GF	11	Systems - MMIS	22	4	26	4	0	4
GF	14	Culture of Safety	1,125	1,500	2,625	1,179	1,179	2,358
GF	13	HCA Admin - FTE (1,1,1,1)	133	153	286	153	153	306
GF	14	ADSA Admin - FTEs (4,5,5,5)	566	825	1,391	825	825	1,650
GF	14	ADSA Admin - Contracts	470	590	1,060	590	590	1,180
GF	REV1	Admin FFP # 32%	(734)	(982)	(1,716)	(854)	(854)	(1,708)
GF	33	MA ED Elderly Waiver MC	0	292	292	1,352	2,975	4,327
GF	33	MA LW Elderly Waiver FFS	0	32	32	150	331	481
GF	33	MA ED EW Home Care MC	0	163	163	755	1,660	2,415
GF	33	MA LW EW Home Care FFS	0	4	4	19	43	62
GF	11	Systems	101	20	121	20	20	40
GF	14	ADSA Admin (FTEs 3,3,3,3)	372	479	851	479	479	958
GF	14	ADSA Admin - Advisory Committee & P/T Contract	1	3	4	3	3	6
GF	REV1	Admin FFP @ 32%	(120)	(154)	(274)	(154)	(154)	(308)
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	14	ADSA FTEs	8	9		9	9	
GF	11	FOD FTE (0.5, 0.5, 0.5, 0.5)	0.5	0.5		0.5	0	
GF	13	HCA FTEs (3,3,3,3)	3	3		3	0	
GF		**Total**	**11.5**	**12.5**		**12.5**	**9**	

Change Item Title: Addressing the HIV epidemic in Minnesota

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	12,100	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)	12,100	0	0	0
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The governor recommends urgent investments to address HIV outbreaks and to ensure that Minnesota is a state where new HIV diagnoses are rare and all people living with HIV—and those at high risk of HIV infection—have access to high quality health care and the resources they need to live long healthy lives, free from stigma and discrimination. This proposal invests one-time funding of $12.1M in the 2024-25 biennium.

Rationale/Background:

The number of people living with HIV is increasing. In 2021, new diagnoses increased 8%, with 298 cases reported compared to 275 in 2019. Recent data shows an estimated 9,696 people with HIV/AIDS (PWH) in Minnesota, 56 percent of whom had HIV (non-AIDS diagnosis). The majority of PWH in Minnesota live in the Twin Cities metropolitan area and surrounding counties, but nearly one in five PWH live outside of the Twin Cities metropolitan area.

In 2020, for the first time in almost 40 years, MDH announced HIV outbreaks in Hennepin and Ramsey counties, as well as the Duluth area. The outbreaks are ongoing and disproportionately impact people injecting drugs and those experiencing homelessness. The effects of the COVID-19 pandemic are widespread. Access to primary health care to prevent and address health issues was diminished for all populations in Minnesota. This includes physical health care, as well as behavioral health care. The prevalence and severity of behavioral health issues, including both mental health conditions and substance use disorders, increased during the pandemic. The pandemic led to disruptions in HIV testing and access to clinical services throughout 2020, impacting HIV diagnoses in 2020. Since the COVID-19 pandemic is still ongoing, more time and data are needed to accurately assess its impact on HIV in Minnesota and the nation.

DHS in partnership with Minnesota Department of Health developed END HIV MN, a legislatively mandated plan to end the HIV epidemic in Minnesota. Services for PWH result in positive individual and public health outcomes. With optimized treatment, we can reduce the amount of HIV in a person's bloodstream to an undetectable level. A sustained undetectable viral load leads to better personal health and means a person can't transmit HIV sexually and reduces the risk of transmitting HIV through injection drug use. The funding requested in this proposal will allow DHS to continue to deliver on the strategies of END HIV MN and help the state reduce new HIV infections by supporting people living with HIV.

DHS administers funding for core medical and support services for eligible people with HIV throughout Minnesota. Funding administered by the HIV Supports Section at DHS includes a mix of funding sources including state grants, federal grants, and special revenue generated through the federal 340B rebate program. Federal funding for this work comes from the Ryan White Program administered by the Health Resources and Services Administration (HRSA). Minnesota currently receives about $8.6 million annually from this source.

In 1998, the HRSA published a final Federal Register notice that allowed state AIDS Drug Assistance Programs (ADAPs) to use rebates to access the drug pricing program authorized by Section 340B of the Public Health Service Act. Revenues generated by the rebate program meant that, historically, Minnesota did not have to limit services, reduce the formulary, or establish a waiting list as other states have had to. Rebate revenue generated by this program has helped to supplement the programmatic budget and for many years only a portion of the revenue was used. DHS was able to accumulate a substantial rebate reserve during this era. As the population of people living with HIV and needing services has grown, DHS has used the rebate funds to address increased needs in the community. Recently, HRSA issued guidance prohibiting states from accumulating large rebate fund balances and requiring spenddowns.

In SFY 2022 DHS received less rebate revenue than the program had forecasted for the year. The shortfall in rebate revenue was partially connected to the COVID-19 Public Health Emergency that reduced the number of people enrolled in and receiving support for medication expenses through the AIDS Drug Assistance Program, as these people stayed continuously enrolled in Medical Assistance. In SFY 2022 DHS also saw very high program expenditures. The increased expenditures were partially due to increased investment of rebate resources in some service activities to meet increased community need due to impacts of COVID-19 and to respond to HIV outbreaks. Increased expenditures in 2022 were also due to higher spending from DHS grantees.

State grants for HIV services support HIV Case Management and insurance access for eligible people with HIV. The State grant funds for HIV services have been relatively stable for many years. The funding level for these services since 2006 has ranged between $2.2 and $2.45 million. While state funding for services for people with HIV has remained relatively flat, the number of people living with HIV has increased substantially. Minnesota averages 300 new HIV cases annually. Minnesota is also currently responding to multiple HIV outbreaks impacting populations in Hennepin County, Ramsey County and the Duluth area. To highlight the growth in people living with HIV, The number of Minnesotans known to be living with HIV in December of 2006 was 5,566 and as of December 2021 was 9,697.

Proposal:

This proposal invests $12.1M in the 2024-25 biennium to prevent immediate and drastic funding reductions during a time of escalated community need and to ensure that DHS can continue to deliver needed services for people with HIV, meeting increased need due to sustained or increased levels of transmission. Funding would support activities for eligible people with HIV including HIV Case Management, insurance and medication access, basic needs support, health education and risk reduction, harm reduction and substance use support. A significant portion of this funding would be administered by DHS to a variety of community partners.

Without an increase in state funding, DHS will need to reduce the HIV operating budget by nearly $9 million annually for SFYs 2024 and 2025 to avoid program deficits. DHS would anticipate reducing the internal administrative budget by approximately $515,000 annually. DHS would also need to reduce the amount for rebate funding passed to Hennepin County Public Health for HIV services in and around the metro area by approximately $1.9 million in SFY 2025 (from approximately $3.1 million in SFY 2024 to approximately $1.2 million in SFY 2025). Reductions would include grantees in Greater Minnesota and programs serving specific cultural communities experiencing HIV disparities. In addition, DHS would reduce funding for many directly funded service areas for people with HIV for SFYs 2024 and 2025. These anticipated reductions would include:

Services area	Anticipated Annual Reduction
Capacity Building and Workforce Projects	$131,000
Emergency Financial Assistance	$ 1,550,000
Food Vouchers/Food Bank/Home Delivered Meals	$ 772,000
Health Education and Risk Reduction	$ 150,000
Medical Case Management	$ 1,150,00
Non-Medical Case Management	$ 665,000
Outpatient Health and Outreach	$ 89,000
Referral Services and Hotline	$ 285,000
TOTAL	**$ 4,792,000**

Additional funding cuts will need to be made to other service areas that are not listed

Impact on Children and Families:

For at least the past five years, about 75 percent of people living with HIV/AIDS in Minnesota were assigned male at birth and about 25 percent were assigned female at birth. Due to advances in preventative perinatal care, transmission of HIV from mother to child is now very rare in Minnesota. We have not had a case of mother to child transmission of HIV since 2017. In the years since (2018-2021) there have been 226 births to pregnant people living with HIV with no HIV infections occurring. Ongoing provision of services to pregnant persons with HIV is crucial to continue this successful outcome.

With these changes, fewer children in Minnesota are living with HIV. As of December 31, 2021, only 27 people under the age of 13 were known to be living with HIV in Minnesota and 70 people from the age of 13-19 were known to be living with HIV. In 2021, there were no new reported diagnoses in those under the age of 13 and there were only 11 new diagnoses for those age 13-19. It should be noted that new HIV diagnoses are disproportionately impacting young adults, ages 20-29, with 89 (out of 298) new diagnoses in 2021 in the age group.

It also important to consider the impact of HIV from an intersectional perspective. With this, certain communities experience higher HIV impact on female-identified people. Male-identified persons make up the majority of Minnesotans living with HIV. However, in black communities (African-born and not African-born), female-identified persons make of the majority of persons known to be living with HIV. Ongoing provision of services prioritizing communities of color is crucial to addressing HIV disparities to support families impacted by HIV and limit further incidence of children living with HIV.

A review of DHS program data for SFY 2022 show that only 1% of clients were under 18. Records also show that almost 10% of clients were households of 2 and 10.4% were households greater than 2.

Equity and Inclusion:

While HIV can infect anyone, there are significant disparities in the rates of HIV transmission and prevalence in Black/African American, Black/African-born, Hispanic, and American Indian communities in Minnesota. To highlight these disparities, almost two-thirds (65%) of new HIV cases diagnosed in 2021 were in communities of color.

The most common known mode of exposure among PWH in Minnesota is male-to-male sexual contact. Portions of LGBTQ+ communities experience HIV disparities, specifically gay men and transgender folks. Persistent racial and ethnic disparities linked to social determinants of health like poverty, unequal access to health care, lack of access to education, stigma, racism, and homophobia exacerbate the unequal HIV care and prevention outcomes we see in our state.

Minnesota is currently experiencing HIV outbreaks in the Twin Cities area and the Duluth area. These outbreaks are disproportionately impacting people who inject drugs and people with unstable housing or unsheltered homelessness.

DHS is the designated agency to received funding to provider core medical and support services for eligible people with HIV throughout Minnesota. DHS is the only entity receiving funds for HIV services that for Greater Minnesota. This proposal would allow DHS to sustain HIV services in Greater MN near their current level of expenditures, supporting geographic equity.

The funding requested in this proposal would allow services activities for communities impacted by HIV to be sustained near their current level of expenditure for SFY 2024. This includes services provided by organizations that prioritize certain cultural communities experiencing the highest burden of HIV impact.

Clients served by DHS reflect these disparate impacts, particularly on communities of color. In SFY 2022, program records show that just under 36% of clients served identified as white. Of the nearly 64% of clients who were from communities of color, almost 28% identified as Black/African American, 13% identified as Black/African-born, 13% identified as Hispanic/Latino/Latinx and the remainder of clients identified with another racial group or as multi-racial.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:

Multiple agencies in Minnesota partner together to lead the response to HIV. The Minnesota Department of Health (MDH) is responsible for CDC-funded HIV prevention efforts, while the Minnesota Department of Human Services (DHS) is responsible for Ryan White Part B and statewide Ryan White services, and Hennepin County Public Health is responsible for Ryan White Part A and Ryan White services in and around the metro area. HIV services funded through DHS are primarily delivered by contracted community providers. Eligibility for services directly administered by DHS HSS is completed by DHS staff and/or contracted community providers, not county staff. Hennepin County's Ryan White Program (HCRWP) receives funding from DHS to support HIV support efforts in and around the metro area. Lead staff from HCRWP have been consulted on this proposal. This proposal would not impact general county operations. It would not incur additional administrative expenses for HCRWP as it would allow existing service levels to be sustained.

IT Costs

This proposal is not expected in incur IT costs.

Results:

This proposal is expected to maintain current spending on HIV supports for people in the community, staving off immediate, drastic reductions decreases in needed services during a time of increased need. Results include:

This proposal will result in people with HIV having have access to care and HIV drugs, leading to decreased transmission of HIV across Minnesota.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			12,100	0	12,100	0	0	0
HCAF								
Federal TANF								
Other Fund								
Total All Funds			12,100	0	12,100	0	0	0
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	55	Disabilities Grants	12,100	0	12,100	0	0	0
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):

None

FY 2024-25 Biennial Budget Change Item

Change Item Title: Department of Children, Youth, and Families Created to Coordinate and Improve Program Delivery

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Minnesota Management and Budget Expenditures	11,931	2,066	0	0
Department of Children, Youth, and Families Expenditures	823	3,521	3,521	3,521
Human Services Expenditures	2,000			
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	
Net Fiscal Impact = (Expenditures – Revenues)	14,754	5,587	3,521	3,521
FTEs	**24**	**30**	**17**	**17**

Recommendation:

The Governor recommends $20,341,000 from the general fund in FY 2024-25 and $7,042,000 from the general fund in FY 2026-27 to support the creation of a new state agency, the Department of Children, Youth, and Families (DCYF), starting July 1, 2024. This includes:

- $3,997,000 for a two-year planning and implementation team and $10 million for a transition appropriation in FY 2024-25 to fund the dedicated capacity to successfully transition and support the new agency in transfer of programs and costs associated with one-time set-up of systems, analysis, engagement, and implementation processes.
- $4,344,000 in FY 2024-25 and $7,042,000 in FY 2026-27 to fund the executive team of the new agency (assuming $3,521,000 annually beginning in fourth quarter FY2024 with $823,000).
- $2,941,000 in one-time appropriation in FY 2024 to Department of Human Services to upgrade the cost allocation plan to leverage federal resources and execute knowledge transfer related to cost allocation, systems account management, compliance, and core functions necessary for oversight in new agency. The expenditures generate federal matching funds which result in a net cost of $2,000,000 to the general fund.

Minnesota Management and Budget (MMB), through a new implementation office and the leadership of the Children's Cabinet, will provide the coordination and capacity for the budget, policy, and administrative planning to transfer programs and associated finances and administrative operational functions from current state agencies to the new agency. These functions will be joined by the new executive team in late FY 2024, leading into FY 2025 and the implementation team will continue to support this work as the new agency begins receiving core programs.

Rationale/Background:

The vitality of our state now and in the future depends on opportunities for the state's children, youth, and families to learn, grow, and thrive. It is imperative that our state programs and systems are highly functional, coordinated, and accessible so that children and families can access the services that help them meet their full potential and that policy and resources can respond to Minnesota child and youth needs now and in the future.

The Minnesota Children's Fiscal Map illustrates a web of 415 programs that serve children and families across 15 state agencies. Coordination is essential to provide efficient and effective funding, policy, and prioritization; to create alignment, ease barriers and streamline service delivery by local providers, and ultimately to make Minnesota the best state for children to grow up. Feedback from families over many years, advocacy, and research in our state and across the nation has led to a call to enhance coordination across our programs and create a clearer access point for Minnesotans – including legislators, local service providers, and families – to lead efforts to improve efficiency and effectiveness for services.

Enhancing coordination and more seamless access to services for families is achieved through a variety of system improvements and structures, including governance. "Governance is the organizational structure that states use to establish and place authority and accountability for decisions about programs, policy, management, financing, and implementation[1]." Minnesota, through the Children's Cabinet structure, currently takes a "coordinated approach," reflecting the fact that Minnesota has programs and services for children and families administered by several state agencies, and no agency with a focus solely on children and families. Creating a Cabinet-level agency focused on children, youth, and families means there will be a commissioner and team are focused on children and families, providing a better pathway to coordination of programs and services for children and elevation of budget and policy needs in the executive branch and at the legislature. It also will provide consolidated connections and communications for service providers (especially early childhood and older youth providers), local governments and Tribes, advocates, and community organizations supporting children, youth, and families.

This proposal would support a transition fund and implementation office necessary to consolidate the core programs from the Departments of Human Services (DHS), Education (MDE), Health (MDH), and Public Safety (DPS) into a new Cabinet-level state agency focused solely on children, youth, and families. The core of the new agency is Children and Family Services, an area of the Department of Human Services, with smaller components of other agencies joining this new cabinet-level agency. The new agency would also include Minnesota IT Services (MNIT) staff from agencies listed above. Programs from other areas at these agencies – and other agencies – will be reviewed and considered for alignment over the course of the transition period and beyond, leveraging existing administrative authority to transfer them where necessary.

The proposal also includes funding directly to DHS to set up the necessary knowledge transfer and cost allocation plans related to federal funding and core function transfer from the Department of Human Services. With the core of the new agency as an elevation of Children and Family Services area of DHS, this allows for leveraging of federal funds from day one of programs being transferred and provides the necessary compliance functions.

The recommendation is built on engagement with advocates, legislators, and families and communities over several years, back to the Early Childhood Systems Reform Report and through the Preschool Development Grant and informed by the Office of Legislative Auditor Report and Early Childhood Governance Report.

Proposal:

This proposal:

- Creates an implementation office and transition appropriation at Minnesota Management and Budget to initiate and plan for the creation of DCYF. The Children's Cabinet will help lead this work.
- Establishes the DCYF in statute – effective July 1, 2024.
- Resources the executive team at the new agency.
- Provides a process for "core" programs at DHS, MDE, MDH and DPS to begin operating at DCYF when transferred between July 1, 2024 and July 1, 2025, and a process to extend or cancel the timeline for programs moving based on transition evaluation.

[1] *State-level governance for early childhood programs in Minnesota.* Management Analysis and Development, January 2022.

- Upgrades the cost allocation plan to ensure DHS and DCYF are prepared to best leverage federal dollars and funds knowledge transfer from DHS. Upgrades the cost allocation plan to ensure DHS and DCYF are prepared to best leverage federal dollars and funds knowledge transfer from DHS.

Details of these elements are described below.

Implementation Office and Transition Appropriation

The implementation office will be housed at MMB. The implementation office will be supported by an investment of $3,997,000 for the salaries, fringe, and overhead for one director, five managers, and up to seven staff (or contract support) over 24 months. This is a onetime appropriation to the Commissioner of MMB. The implementation office will be responsible for leading the planning and establishment of DCYF, including timeline for the transition of programs to the new agency, and elements related budget, finance, legal, human resources, IT, policy, public engagement, and project management skills.

This proposal also includes a transition appropriation of $10 million for the purposes of implementation team needs, building the shell of a new agency, planning costs to best leverage federal funding, and onetime transition costs at existing agencies. This is a onetime transition appropriation to the Commissioner of MMB in FY 2024. The commissioner of MMB may transfer the funds held in the transition account to other agencies. The transition appropriation will fund costs associated with: engagement (travel, contract support, and IT); management, hiring support, and change management expertise; administrative costs (equipment; mailing, supplies); equity analysis; occupancy costs; IT (one-time set up costs for new agency and implementation team needs); and funds to support the bridge in transfer of base operating funds.

Create New Agency

DCYF will be effective July 1, 2024 and will have a commissioner appointed by the governor and starting that day. The agency will be able to start receiving new programs as soon as it opens but will have 12 months to complete the transfer of the core programs described below.

The proposal includes funds for an executive team commensurate with agencies of similar size, annually beginning in the final quarter of fiscal year 2024. This includes a Commissioner, Deputy Commissioner, Assistant Commissioners, Budget Director, Accounting Manager, Tribal Office Director, General Council, Compliance Officer, and other key roles.

Transfer responsibilities to new agency

Starting no later than July 1, 2025, the “core” programs listed below will operate from the new department, along with related administrative operational functions. Additional programs may be considered during the 2023 session and, if passed, would be added to the core programs.

Responsibilities that are not listed below may be transferred using the processes described in MS 16B.37. This proposal requires a Revisor bill and potentially other conforming changes to be considered in the 2024 session.

With the creation of a new agency, Minnesota Statutes section 16B.37 could be leveraged to execute administrative reorganization orders between departments that improve efficiency and avoid duplication in government, including transfer of personnel, powers, and duties from a state agency to the newly created state agency.

Base programs under consideration for first wave "core" that would be transferred to DCYF by July 1, 2025:

Currently at DHS – Children & Family Services

- Oversight of Federal Child Care & Development Block Grant
- Child Care Assistance Programs
- Child Care Service Grants
- Child Care Resource and Referral Program
- Family Services and Community-Based Collaboratives
- Child Development Services
    - Child Care Service Grants
    - Child Care Resource and Referral Program
    - Quality Rating System
    - Migrant Child Care Program
    - Child Care Improvement Grants
    - Retaining Early Educators Through Attaining Incentives Now (REETAIN) Grant Program
    - Teacher Education And Compensation Helps (TEACH)
    - Child care professional development and training system
- Early Childhood Learning and Child Protection Facilities Program
- SNAP (including)
    - SNAP E&T
    - SNAP Outreach
    - SNAP-Education
- The Emergency Food Assistance Program
- Minnesota Food Assistance Program
- P-EBT
- MFIP/TANF
- Diversionary Work Program
- Whole Family Systems
- Resettlement Programs
- Community Action Programs
- Child Protection
- Family Preservation
- Child Welfare Prevention
- Continuous Quality Improvement
- Research and Evaluation
- SSIS
- Northstar Care for Children (encompasses foster care, adoption, and kinship care)
- Title IV-E
- Adolescent Services
- African American Well Being unit
- American Indian Well Being unit
- Child Welfare Training Academy
- Child Support

Currently at DHS – OIG

- Licensure Of Child Care, Foster Care
- Certification Of License-Exempt Child Care Centers
- Program Integrity/Fraud Related To CCAP, MFIP, and SNAP

Currently at MDE

- Programs within Early Learning Services Division
    - Head Start Program / Early Head Start
    - Early Childhood Health and Developmental Screening
    - Early Learning Scholarships
        - Part C Early Intervention Services
- Preschool Development Grant (PDG)
    - Mixed Delivery Pre-K (2023 Governor's Budget Proposal with full implementation starting in 2026. Consolidates existing Voluntary PreK, School Readiness Plus and Pathway II Early Learning Scholarship funds)
    - Early Childhood Family Education
    - School Readiness
- After-School Community Learning Grant Program (2023 Governor's Budget Proposal)

Currently at DPS

- Youth Justice Office
    - Juvenile Justice Advisory Committee
    - Youth Intervention Program grant

Currently at MDH

- Help Me Connect (2023 Governor's Budget Proposal)

Appropriation to Department of Human Services

The proposal includes funding for a Public Assistance Cost Allocation Plans (PACAP) contract analysis necessary to ensure all federal funds are leveraged at both the new agency and DHS and upgrades the existing platform to create a new platform for the cost allocation system at both agencies by July 1, 2024.

The proposal also includes resources for training related to knowledge transfer of cost allocation, systems account management, compliance, and core functions to provide controls and oversight in new agency necessary to best leverage federal resources for more effective and efficient systems.

Impact on Children and Families:

The mission of the proposed new agency will be to make Minnesota the best place for children to grow up by prioritizing children and youth in state government, and by providing coordinated, whole-family-focused services that improve the lives of children and families through efficient, effective governance. This budget proposal builds on the work of the Children's Cabinet to convene, align, coordinate, and drive action toward the goal in Executive Order 19-34 to center children and family in state government and make Minnesota the best place for each and every child to grow up.

This change provides an opportunity to better prioritize children in our state government systems, especially our children who face barriers to opportunities and access to services, focused on culturally relevant services, including children of color and indigenous children, lower income children and children in rural areas. The new agency will provide a consolidated and sustainable structure to drive action toward improved outcomes for children and youth, specifically through consolidation of key early childhood programs, programs that support family basic needs, and creating platform for a transformational programming for children and youth. For instance, a main goal of DCYF is to consolidate and better coordinate early childhood programs to streamline and improve services and outcomes for children, families, and the early childhood workforce. Building off existing early childhood system coordination efforts, the Great Start for All Minnesota Children Task Force, Office of Legislative Auditor Report 2018, and feedback from providers and early childhood advocates that support consolidation, the DCYF will allow for more seamless implementation and further development of plans and implementation timelines to improve the early childhood system including (not limited to):

- Simplifying navigation, application and eligibility for early childhood programs;
- Building off existing IT improvements, creating a more seamless registration, payment and licensing and regulatory services for child care providers; and
- Implementing and aligning recruitment, training and retention activities to better support and grow the early care and education workforce.

Similarly, creating an agency with a focus on prevention and support for youth will create a more integrated approach and provide opportunity to better elevate needs and increase funding for youth by:

- Consolidating where several state youth grant programs are administered – creating a unified platform for new community opportunities– reducing the burden and streamlining connection and communication with youth-serving programs;
- Building on existing cross-agency efforts to better align state strategies to support youth, especially those who are involved with multiple state systems (e.g., child welfare and justice systems); and
- Elevating youth voice, priorities, and needs through more youth-focused leadership and governance structure.

This proposal is based on years of discussion and engagement with families, advocates, service providers, tribes, local partners, national organizations, and other states. The proposal is informed by the Early Childhood Governance report and engagement issued in January 2022, consolidation efforts centered on children, youth and families in other states, and the family and partner engagement across state systems and structures (Preschool Development Grant, Title V, Early Childhood Systems Reform, Child Care and Development Fund Plan, Children's Cabinet Advisory Councils, etc.). In each of these engagements, families and partners have said they wanted

increased service and program coordination and simpler service navigation. The proposed process also creates the DCYF to allow for continued input from the community, as core services transition over two years, and other services are considered for future inclusion. This process, led and supported by a fully resourced implementation office, will also help to minimize disruption in services.

Based on research, governance experts, engagement with stakeholders, and lessons from other states that have consolidated programs into a child-focused agency, the Early Childhood Governance Report included the following provisions on what needs to happen for successful consolidation of programs into a new state agency focused on children:

- Start with key challenges (raised through engagement with families, communities, and agency staff and programs).
- Plan for governance change, using dedicated staff, resources, time (proposed in this budget item).
- Engage with leaders and secure buy-in (ongoing, and an underpinning of the proposal).
- Figure out the nuts and bolts of business systems (funded through the transition process).
- Factor in and sort out the implications of a governance change for local service providers and state-local roles (funded through the transition process).
- Determine the funding and resources needed to advance the state's childhood efforts (ongoing).

This proposal provides the resources, capacity, and time necessary to follow this advice to help ensure a successful launch of the new DCYF. Experience in other states has demonstrated that consolidation of key state programs for children, youth, and families helps to center children in state government and create a clear focus on improving outcomes for children. As a county-administered state with tribes also administering programs, careful consideration for local level service delivery in transition and implementation will be important.

Equity and Inclusion:

The new agency will aim to reduce and eliminate inequities, improve service access and coordination, and increase and maximize funding for effective interventions. These efforts will include a focus on services and interventions that are culturally relevant/affirming for children of color and indigenous children, children with disabilities, children and families experiencing trauma, LGTBQIA+, families where English is not the primary language, and the workforce that serves them, as well as other protected classes. The new agency will center equity in its decision-making and work to amplify and include voices of these key groups at the center of their engagement and decision processes. The new agency structure allows for a centering in policymaking, creating opportunity for new, coordinated investment to reduce inequities. The implementation office will conduct an equity analysis and provide it to the new commissioner.

Creating a new agency through consolidation of existing programs is disruptive and has risks not only for the State, but also for the key partners the programs fund and provide services. Some potential negative impacts include staffing and capacity challenges (unwinding existing agency staffing and administrative structures), confusion and communication challenges for key partners (e.g., not knowing where to go for support), and impeding progress on existing coordination efforts. A new agency can also create confusion and additional channels for tribes, counties, and service providers, yet these result from additional opportunity for investment. This proposal is designed to mitigate these challenges through the transition process and leadership of the implementation team. This should minimize disruption on state staff, local government and community partners, and, most importantly, children, youth, and families who access programs, especially those in these identified groups.

This proposal is built upon high-level engagement through numerous cross-agency venues/tables including:

- the Children's Cabinet Advisory Council and State Advisory Council for Early Education and Care (convened together)
- the cross-agency federal Preschool Development Grant (families, providers, and community leaders)

- discussions and interviews with 100+ community stakeholders and early childhood advocates as part of the Early Childhood Governance Report
- discussions with leaders in other states with consolidated child-focused agencies, and input from current and past state agency leaders.

More specific conversations are needed with unions, local government and nonprofit program administrators, child and youth advocates, and other community leaders and families.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

All 11 Minnesota Tribal Nations will need to engage with a new agency for key programs that some of them administer and all have children and families who access, and thus will be impacted, and potentially some more than others (e.g., Tribes that administer state programs that will be moved to the new agency). Administration leaders have shared this proposal with tribal leaders at the Minnesota Indian Affairs Council, weekly tribal leader calls, and through individual outreach, where possible. Further engagement and dialogue is ongoing and an important priority as the proposal moves forward.

Representatives from tribes were included in engagement where governance changes were discussed including through the development of the Early Childhood Governance Report, Preschool Development Grant engagement, and the Children's Cabinet Advisory Councils conversation on governance changes. Based on discussion with the Executive Director of Tribal Relations, tribal consultation was not essential as it is related to state government administration, however, early and ongoing tribal engagement will be necessary to ensure the needs of indigenous families are prioritized and positively impacted and consultation will be a component of new agency.

Specific Tribes have not indicated this as a priority, though the need for a child and youth-oriented agency has been lifted up in discussions with tribes and tribal organizations. For example, representatives on the Tribal Nation Education Committee (TNEC) have expressed support for consolidation of early childhood programs into one agency. Through feedback and relationships, tribal leaders have shared a desire for more funding and resources oriented to youth opportunity and family economic needs; centering these programs outside of systems aligns with this feedback.

More engagement is necessary to understand the Tribes' perspectives and considerations. Coordination on the communication plan will occur through Tribal Relations leadership in the Governor's office and with their feedback. The Tribal and Urban Indian Health Directors group, coordinated jointly by the Minnesota Department of Health (Office of American Indian Health) and Minnesota Department of Human Services (Office of American Indian policy) will be consulted at a future meeting. This group would be able to provide feedback including perspective and considerations as this proposal advances. The Tribal Nation Education Committee (TNEC) and Minnesota Tribal Resources for Early Childhood Care (MNTRECC) were consulted for the Early Childhood Governance report and will continue to be key groups to engage.

Results:

The statute creating the Department of Children, Youth, and Families will require the commissioner to develop program objectives as well as performance measures for evaluating progress toward achieving such objectives. The commissioner must identify the objectives, performance measures, and current status of achieving these measures in a biennial report to the chairs and ranking minority members of relevant legislative committees and divisions. The report is due January 15th every other year.

Change Item Title: Direct Care and Treatment FY 2023 Operating Deficiency

Fiscal Impact ($000s)	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027
General Fund					
Expenditures	4,829	0	0	0	0
Revenues	0	0	0	0	0
Other Funds					
Expenditures	0	0	0	0	0
Revenues	0	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	4,829	0	0	0	0
FTEs Maintained	**0**	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends appropriating $4.8 million in FY 2023 to address the operating deficiency for the Department of Human Services (DHS) Direct Care and Treatment (DCT) services. This appropriation will provide the resources DCT needs to continue providing services to patients and clients and address capacity issues resulting from the priority admission law.

Rationale/Background:

DCT is a large, highly specialized behavioral health care system that provides care to about 12,000 people a year. Most of the people served by DCT are civilly committed and have complex mental health needs and behavioral challenges. They are individuals who private providers cannot or will not serve. DCT serves a unique role in Minnesota's behavioral health treatment continuum, providing the most specialized services to those with the most complex needs.

DCT operates an extensive statewide network of psychiatric hospitals and other inpatient mental health facilities, substance use treatment facilities, group homes and vocational services for people with disabilities, and special care dental clinics. It also operates the nation's largest program for civilly committed sex offenders.

Like every other health care system that operates 24 hours a day, 365 days a year, DCT is staff intensive. Personnel costs make up more than 85% of the total operating expenditures. State and federal law demand that DCT maintains safe staffing levels. This has been extraordinarily challenging and costly with the dual effects of the COVID-19 pandemic and health care workforce shortage.

In the face of vacancies and illness, DCT has relied heavily on overtime and bonus pay to fill shifts and maintain safe staffing levels.

As of January 13, 2023, year-to-date overtime and premium pay expenses total $19.7 million and have exceeded the annual General Fund budget by more than $5 million, with more than five months remaining in the fiscal year.

Proposal:

The recommended funding will close the gap between operating expenditures and available funding. Operating expenditures include personnel and non-personnel expense.

Personnel expense includes, but is not limited to: full and part-time salary, overtime, premium pay, fringe benefits, and workers compensation and unemployment insurance.

Non-personnel expense includes: food, drugs, medical supplies, building maintenance and repairs, utilities, professional contracts, and all other costs associated with operating a health care system 24 hours a day, 365 days a year.

Impact on Children and Families:

This proposal does not directly relate to this initiative.

Equity and Inclusion:

DCT operates an array of residential and treatment programs serving people with mental illness, developmental disabilities and chemical dependency. Many of those DCT serves are also part of one or more of the following groups: BIPOC, people with disabilities, people in the LGBTQ community, other protected classes, and veterans. Throughout this planning process, DCT will ensure equity and inclusion are central to DCT's continued care and services.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:

This proposal is not expected to impact counties.

Results:

Funding this proposal will ensure that DCT has the resources needed to maintain safe staffing levels to continue to provide treatment and services to individuals with mental illness and those civilly committed to the Minnesota Sex Offender Program.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY23	FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			4,829						
HCAF									
Federal TANF									
Other Fund									
Total All Funds									
Fund	**BACT#**	**Description**	**FY23**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	65	DCT Admin	4,829						
		FTEs Maintained							
Fund	**BACT#**	**Description**	**FY23**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Change Item Title: MA enteral feeding product rate methodology change

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund	830	2,399	2,480	2,523
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	26	59	66	69
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	856	2,458	2,546	2,592
FTEs	**0**	**0**	**0**	**0**

Recommendation:
The Governor recommends updating the pricing methodology for enteral nutrition and supplies in the Medical Assistance (MA) durable medical equipment (DME) benefit. This proposal will result in a General Fund impact of $3,314,000 in the 2024-2025 biennium and $5,138,000 in the 2026-2027 biennium.

Rationale/Background:
Enteral nutrition and supplies should be individually priced (see 256B.766, paragraph (i)). However, currently, approximately half of the products have a designated rate, and the other half are individually priced. For the items that are individually priced, when providers bill for these products, they are required to submit information in an attachment that includes either the manufacturer's suggested retail price (MSRP) or, if the MSRP is not available, invoice. Given the large volume of enteral products provided in MA, providers have shared concerns about the administrative burden of submitting claims attachments.

Proposal:
This proposal establishes a new rate methodology for enteral nutrition and supplies in the Medical Assistance program. The new methodology would be set using a percentile of submitted charges for specific products in order to account for the uniqueness and pricing variability for each product. The methodology includes data thresholds and caps annual increases in an effort to ensure consistency in the data used to calculate reimbursement rates. Consistent with other DME methodologies, the enteral rates are then updated annually with new data.

Impact on Children and Families:
A large portion of enteral nutrition are supplied for children in the Medical Assistance program. This new methodology is intended to recognize that each product is unique and thus allowing access to the product that best meets the child's needs.

Equity and Inclusion:
This proposal does not directly impact equity. However, all enrollees benefit when providers are paid a fair and transparent price.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
This proposal does not impact counties.

IT Costs
There are no systems costs required for this proposal.

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of enteral products priced correctly	50%	Fall 2022	50%	100%	Summer 2023

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
General Fund			830	2,399	3,229	2,480	2,523	5,003
HCAF			26	59	85	66	69	135
Federal TANF								
Other Fund								
Total All Funds			856	2,458	3,314	2,546	2,592	5,138
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	33ED	MA Grants	626	1,853	2,479	1,878	1,912	3,790
GF	33AD	MA Grants	5	11	16	12	12	24
GF	33FC	MA Grants	199	535	734	590	599	1189
HCAF	31	MinnesotaCare Grants	26	59	85	66	69	135
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):
256B.766

Change Item Title: Hospice Respite and End-of-Life Care for Children on MA

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	64	95	95	95
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	64	95	95	95
FTEs	**0**	**0**	**0**	**0**

Recommendation:
The Governor recommends creating a Medical Assistance benefit for hospice respite and end-of-life care for children. This proposal requires a General Fund investment of $159,000 in the FY2024-2025 biennium and $190,000 in the FY2026-2027 biennium.

Rationale/Background:
Currently, when a child requires hospice and end-of-life care, they receive these services either at their home or in the hospital. Residential hospice services have long been an option for adults. However, Minnesota's only currently operating residential pediatric hospice facility does not meet the physical plant criteria for participation in the Medicare program. Compliance with Medicare criteria is a requirement for participation in the Medicaid program. Given the essential nature of the benefit and its value to families, the Governor recommends reimbursing the facility with state only dollars. Respite care is defined as a 3-5 day stay to give the child's parent/caregiver a break from the demands of 24/7 medical care at home. End-of-life care is defined as a stay at the residential hospice facility when the child is on hospice and near the end-of-life or at the end-of-life, along with his or her family.

Proposal:
This proposal will establish state funded Medical Assistance coverage for hospice respite and end-of-life care for recipients under 21 at 100% of the Medicare rate for continuous home care hospice services. This proposal is funded with 100% state funds.

Impact on Children and Families:
In Minnesota, thousands of children die every year of complex chronic conditions, rare diseases, cancer, neurodegenerative, neuromuscular and heart and lung diseases. This proposal will allow children enrolled in Medical Assistance, and their families, the option to choose between in-home care or care in a facility that is dedicated to the needs of the child and their family.

Equity and Inclusion:
This proposal does not have a direct impact on health disparities. However, it provides additional options for respite and end-of-life care for children enrolled in Medical Assistance.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
This proposal does not impact counties.

IT Costs
IT systems changes would be required to implement this change in the Medicaid Management Information System, MMIS, which is Minnesota's automated system for payment of medical claims and capitation payments for the Medical Assistance and MinnesotaCare programs. These systems changes are estimated to require 333 hours of work, take approximately two months to complete, and cost a total of $34,615 for initial development. Because this proposal is not eligible for FFP, state share is assumed at 100%.

Results:

Type of Measure	*Name of Measure*	*Current Value*	*Date*	*Projected Value (without)*	*Projected Value (with)*	*Date*
Quantity	Number of children receiving this care via MA	0	Dec 2022	0	12	Annual

Fiscal Detail:

Net Impact by Fund (dollars in thousands)	FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund	64	95	159	95	95	190
HCAF						
Federal TANF						
Other Fund						
Total All Funds	64	95	159	95	95	190

Fund	BACT#	Description	FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
GF	33FC	MA Grants	29	88	117	88	88	176
GF	11	State share of systems costs	35	7	42	7	7	14
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**

Statutory Change(s):
Minnesota Statutes, section 256B.0625

Change Item Title: MFIP Sanction Reform and Housing Assistance

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	990	1,990	3,901	4,354
Revenues	0	0	0	0
TANF Fund				
Expenditures	414	3,257	6,357	6,820
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	1,404	5,247	10,258	11,174
FTEs	**3**	**3**	**3**	**3**

Recommendation:

The Governor recommends investments of $2.9 million from the general fund and $3.7 million from the TANF fund in FY 2024-25 and $8.2 million from the general fund and $13.2 million from the TANF fund in FY 2026-27 to reform Minnesota Family Investment Program sanction policies and help families with children keep up with the cost of housing. This proposal also includes staff to work with local agencies and tribal nations to implement these changes.

Rationale/Background:

The Minnesota Family Investment Program (MFIP) is the state's cash assistance program for families with children. MFIP provides income support, food benefits, and employment services to help low wage workers with children. Program rules include work requirements and a time limit of no more than five years assistance over a parent's lifetime.

In 2013, the legislature approved a housing assistance grant ($110 per month) to assist families with children participating in MFIP with the cost of housing. The amount of the housing assistance grant has not changed since it was implemented in 2015. To be eligible for the housing assistance grant, a family participating in MFIP must not be receiving a housing subsidy through the Department of Housing and Urban Development. According to the Department of Housing and Urban Development, fair market rent[1] for a 2 -bedroom apartment in the Twin Cities Metro is currently $1,410 per month and has increased 42% since 2015. In greater Minnesota, the average fair market rent for a 2-bedroom apartment is currently $988 per month and has increased 32% since 2015.

The Minnesota Family Investment Program (MFIP) sanction policy is extremely complicated. Parents receiving assistance from MFIP can lose some or all of their families' assistance if they are not complying with program rules. Sanctions are intended to encourage compliance but the complexity of the policy makes the sanctions unpredictable. Currently:

- Minnesota has different sanction policies for different types of cases;
- Tracking sanctions is required across time – even for people who have gaps in program participation; and

[1] Fair market rents represent the cost to rent a moderately-priced dwelling and are estimates of 40th percentile gross rents for standard quality units within a metropolitan area or nonmetropolitan county (United States Department of Housing and Urban Development)

- Restoring benefits is based on when someone comes back into compliance but benefits can't be restored retroactively if someone comes back into compliance quickly.

The current process involves extensive frontline worker time and resources, and creates inconsistency throughout the state in applying sanctions. Counties and Tribal Nations could spend less time interpreting, tracking, and imposing sanctions and more time determining benefit amounts and helping families access services to get a job or maintain employment. The families who turn to MFIP due a job loss, a health crisis, homelessness, or other events that leave them in deep poverty would be positively impacted by reforming the sanction policies. Families with children receiving MFIP would be better off because the sanction process would be easier to understand and would give them opportunities to resolve barriers to compliance as they come up and focus more on finding and keeping a job. Research findings suggest that many sanctioned recipients fail to comply with program requirements not because they are resistant to them but rather because they face barriers that make it difficult for them to meet such requirements.[2]

Proposal:

A cost of living adjustment would be made each year to the Minnesota Family Investment Program (MFIP) housing assistance grant at the start of the federal fiscal year, October 1, starting in 2024. The adjustment would be based on the Consumer Price Index. This would allow incremental increases in the housing assistance grant that many children and their families receive. Low wage workers in retail, hospitality, food service, health care, and temporary agencies account for the vast majority of adults who turn to MFIP when unemployed or underemployed. These industries are characterized by high turnover of workers and part-time hours, often with unpredictable schedules outside the workers' control. This unpredictability impacts the income of families receiving MFIP. Providing a modest increase to assist families with children with the rising cost of housing would help families stabilize more quickly.

This proposal also reforms the MFIP sanction policies. This proposal balances participant accountability, program predictability, and administrative ease for frontline workers. The impetus for this policy change is twofold; a clear, understandable, and precise sanction policy will engage participants more effectively and earlier. Secondly, current sanction policy confuses workers and participants. Reforming the sanction policy would increase client engagement, lessen county and tribal workloads, increase program consistency and integrity, and be more easily automated. The proposed policy eliminates distinct sanction policies based on how long someone has been receiving MFIP, increases the incentive to cooperate by more promptly restoring full benefits when participants return to compliance, and eliminates the need to keep counts of sanction occurrences dating back to 2003.

This proposal includes 3 FTEs to ensure local agencies have adequate support when implementing this change. One FTE will ensure policy changes and systems updates are implemented according to the intent of the legislation. This position will also work on policy updates and communications with counties and Tribal Nations. The second position will join the Policy Center team to work on manual updates and work with policy staff to answer questions from counties and Tribal Nations across the state. A third position will join the Instructional Design team and will update the training curriculum and provide training to counties and Tribal Nations on the policy changes.

	Current Policy	Reform Proposal
MFIP benefit sanctioned	Sanction both the cash and the food portion of the MFIP benefit. The sanction amount is determined by the percentage of the maximum cash and food benefit per household size.	Sanctions would only be applied to the cash portion of the MFIP benefit. The sanction amount is determined by the percentage of the cash grant received by the household.

[2] Kauff, et al., 2007. The Sanction Epidemic in the Temporary Assistance for Needy Families Program.

Number of sanctions before closure	For pre-60 month cases, a case is closed on the 7th sanction occurrence.	MFIP case is closed due to 7 consecutive sanction occurrences for all MFIP cases.
Sanction count	Counts MFIP sanctions on a running total over the lifetime of a case. For instance, a sanction that occurred at any time whether last month or 7 years ago is counted in the sanction count.	If a case comes into compliance, the sanction count will start back at zero.
Sanction tracks and percentages	There are 2 sanction "tracks" for MFIP families: • Pre-60 Month cases – Allows for 6 sanctions before a MFIP case is closed on the 7th sanction. This policy has a 10% sanction on the cash and food portion for the first occurrence, a 30% sanction for occurrence's 2-6, and then case closure on the 7th occurrence. • Post-60 Month cases – Allows for 3 sanctions before a MFIP case is closed on the 4th occurrence. This policy sanctions the first occurrence at 10% and occurrences 2 and 3 at 30% of the cash and food portion and then case closure on the 4th occurrence.	One single sanction "track" for all MFIP families. For the first, second, third, fourth, fifth, and sixth consecutive sanctions for noncompliance with employment & training or orientation, there would be a 5% sanction on the cash portion received by the household. On the 7th consecutive sanction, the case would be closed.
Sanctions for refusal to cooperate with child support	Sanctions for refusal to cooperate with child support requirements are set at 30% of the applicable MFIP standard of need.	Sanctions for refusal to cooperate with child support requirements are set at 25% of the cash portion received by the household. This will require a dual sanction policy in cases where a client is out of compliance with orientation/E&T AND child support. In these cases, the sanction amount must be 25%.
Reapplication policies for MFIP cases that have been closed due to sanction	Different rules for pre- and post-60 month families that have been closed for sanctions and have reapplied for MFIP: • Pre-60 month cases – Can reapply for MFIP after case closure due to sanction. For first sanction after 1st closure and reapplication will be sanctioned at 30% of the cash and food portion. On the 2nd sanction a case is closed. Pre-60 month cases that have been closed twice due to sanction can reapply and any subsequent sanction will result in closure. • Post-60 month cases – Can reapply for MFIP after case closure due to sanction. For first sanction after	There would be no different policy for pre- or post-60 month cases that closed due to sanction. One single sanction "track" for all MFIP families. For the first, second, third, fourth, fifth, and sixth consecutive sanctions, there would be a 5% sanction on the cash portion. On the 7th consecutive sanction, an MFIP case would be closed. No permanent disqualification. Allow a closed MFIP case to come back onto MFIP after 30 days of closure, completing a reapplication, and being in compliance for up to 30 days after reapplying. No assistance paid during this period.

	closure and reapplication will be sanctioned at 10% and if a 2 sanction occurs the case is permanently disqualified.	
Sanction curing and grant restoration	Allows for sanctions to be cured by the end of the month in which the sanction is imposed allowing for the full MFIP grant to be restored for the following month.	If a sanction is cured by the 15th of a month in which the sanction is being imposed, the sanction amount can be restored through a supplement to the MFIP grant. If the sanction is cured after the 15th of the month and before the end of the month which the sanction is imposed then the full MFIP grant for the following month is restored (same as current policy).
Vendor payments	Requires vendor payments for shelter costs on any 30% sanction. Vendor payments are also required for 6 months after a case comes into compliance.	No requirement to vendor pay for shelter costs.
Hardship extensions	Requires that a family be in compliance in the 60th month if the case is to be considered for a post-60 month hardship extension.	No requirement that a family be in compliance in the 60th month to be eligible for a post-60 month hardship extension.
Hardship extensions	Requires families with an employed participant be in compliance for at least 10 months in the past 12 months to be eligible for a post-60 month hardship extension.	No requirement to be in compliance for 10 months out of the past 12 months to be eligible for a post-60 month hardship extension for families with an employed participant.
Permanent disqualification	Employed participants with a post-60 hardship extension who fail to meet work requirements can be sanctioned or permanently disqualified.	These participants can still be sanctioned or closed but are not subject to permanent disqualification.

Impact on Children and Families:

The Minnesota Family Investment Program (MFIP) is the primary income support program provided to children in deep poverty and their families. Women are 82% of the adults enrolled in MFIP and there are approximately 48,000 children in families that have turned to MFIP. More than half the families that have turned to the program have a child younger than six.[3] A study in twenty cities in fifteen states of mothers who had received TANF in the prior twelve months found that 42% of those who had been sanctioned and 27% of those who had not been sanctioned reported experiencing one or more of the following four hardships: maternal or child hunger; eviction or homelessness; utility shutoff; and inability to receive medical care due to cost.[2] Sanctions inflict severe hardship on the state's neediest families. Adding a cost of living adjustment to the MFIP housing assistance grant and reforming the MFIP sanction policies will disproportionately benefit families with children and women. These families will have more benefits to support housing, child care, and other necessary family expenses.

[3] Minnesota Department of Human Services, Minnesota Family Investment Program and Diversionary Work Program: Characteristics of Cases and People, 2020.

Equity and Inclusion:

African American adults are 33% of the Minnesota Family Investment Program (MFIP) caseload[4] but only 7% of state residents.[5] American Indian adults are 6% of the MFIP caseload but only 1.4% of state residents. Overall, people of color and American Indians make up 64% of the MFIP caseload but are 21% of state residents. According to an analysis of program data, Black, American Indian, and Hispanic participants were more likely to be sanctioned than white participants from 2008-2018.

The paperwork burden and the unpredictability caused by program complexity add to the stress already imparted by poverty and discrimination experienced by the people we serve. Low wage workers in retail, hospitality, food service, health care, and temporary agencies account for the vast majority of adults who turn to public assistance when unemployed or underemployed. They are also the industries in which people of color and American Indians receiving MFIP are most likely to be employed.[6] These jobs are subject to inconsistent work schedules, high turnover, and few benefits. The public assistance system they turn to during a time of crisis is unnecessarily complicated. The proposed policy changes will disproportionately benefit these workers by helping them maintain stable housing and making the sanction process easier to understand.

Public Engagement:

This proposal is based on a proposal from 2019 that was developed by a DHS convened work group of representatives from counties, Tribal Nations, employment services providers, advocates, and MNIT.

Impacts to Counties:

The MFIP housing assistance grant cost of living adjustment will be fully automated and will not impact counties. The current sanction process involves extensive frontline worker time and resources, and promotes inconsistency throughout the state in applying sanctions. Reforming the sanction policies has the potential to increase client engagement, lessen county workloads, and increase program consistency and integrity. The MAXIS eligibility system will be reprogrammed to automate these changes to the MFIP sanction process. If these changes are fully implemented, there will likely be fewer questions from counties about how to count sanctions for families with children receiving MFIP.

Impacts to Tribes:

The MFIP housing assistance grant cost of living adjustment will be fully automated and will not impact Tribal Nations that administer MFIP. The current sanction process involves extensive frontline worker time and resources, and promotes inconsistency throughout the state in applying sanctions. Reforming the sanction policies would increase client engagement, lessen workloads, and increase program consistency and integrity. The MAXIS eligibility system will be reprogrammed to automate these changes to the MFIP sanction process. If these changes are fully implemented, there will likely be fewer questions from Tribal Nations that administer MFIP about how to count sanctions for families with children.

Results:

A cost of living adjustment for the MFIP housing assistance grant will put in motion an automatic increase that will continue to incrementally improve the well-being of children in deep poverty. In 2024, this is estimated to be an additional $5 for a total of $115 per month. By 2027, it is estimated to be a total of $123 per month.

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[4] Minnesota Department of Human Services, Minnesota Family Investment Program and Diversionary Work Program: Characteristics of Cases and People, 2020.
[5] U.S. Census, QuickFacts, Minnesota, 2021.
[6] Minnesota Department of Employment and Economic Development, Minnesota Economic Disparities by Race and Origin, 2020.

Studies that examine the well-being of Temporary Assistance for Needy Families (TANF) recipients consistently find high rates of hardship with respect to basic needs such as housing, food, utilities, and medical care.[7] Studies also consistently find high hardship rates with respect to basic needs among sanctioned families. The studies that report hardship rates for both sanctioned and non-sanctioned families consistently report higher rates for sanctioned families.[2]

IT Related Proposals:

MNIT costs for the MFIP housing assistance grant cost of living adjustment. DHS should calculate FFP as applicable.

MAXIS	2024	2025	2026	2027
Cost by System	$116,100	$0	$0	$0
Operational Cost	$0	$23,220	$23,220	$23,220
Total Cost	$116,100	$23,220	$23,220	$23,220
Total of All System Costs by Fiscal Year	**$116,100**	**$23,220**	**$23,220**	**$23,220**

MNIT costs for the MFIP sanction reform proposal. DHS should calculate FFP as applicable.

MAXIS	2024	2025	2026	2027
Cost by System	$667,270	$0	$0	$0
Operational Cost	$0	$133,454	$133,454	$133,454
Total Cost	$667,270	$133,454	$133,454	$133,454
Total of All System Costs by Fiscal Year	**$667,270**	**$133,454**	**$133,454**	**$133,454**

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 24	FY 25	FY 24-25	FY 26	FY 27	FY 26-27
General Fund			990	1,990	2,981	3,901	4,354	8,255
HCAF					-			-
Federal TANF			414	3,257	3,672	6,357	6,820	13,178
Other Funds								
Total All Funds			1,404	5,247	6,653	10,258	11,174	21,434
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
TANF	21	Sanction Reform - MFIP	-	2,306	2,306	5,157	5,361	10,519
GF	21	Sanction Reform - MFIP	-	830	830	1,857	1,930	3,786
GF	22	Sanction Reform - MFIP Child Care	-	93	93	800	996	1,796
TANF	21	Housing Grant COLA - MFIP	414	951	1,365	1,200	1,459	2,660

[7] Legal Momentum (July 2009). Meager And Diminishing Welfare Benefits Perpetuate Widespread Material Hardship For Poor Women And Children.

GF	21	Housing Grant COLA - MFIP	294	676	970	853	1,037	1,889
GF	11	Systems costs (MAXIS and MEC2) @ 55% - sanction reform	367	73	440	73	73	147
GF	11	Systems costs (MAXIS and MEC2) @ 55% - Housing Grant COLA	64	13	77	13	13	26
GF	12	Children and Families Admin	390	449	839	449	449	898
GF	REV	FFP @ 32%	(125)	(144)	(268)	(144)	(144)	(287)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 24**	**FY 25**	**FY 24-25**	**FY 26**	**FY 27**	**FY 26-27**
GF	12	Children and Families Admin	3	3		3	3	

Statutory Change(s):

256J.35, 256J.425, and 256J.46

Change Item Title: Supporting Children and Families

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures				
DHS	316	63	63	63
Revenues				
Tax Aids, Credits, & Refunds	(825,900)	(856,200)	(874,300)	(889,900)
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	826,216	856,263	874,363	889,963
FTEs				

Recommendation:

The Governor recommends expanding tax programs for families with children, including –

- Establishing a refundable, state-based Child Tax Credit for households with children younger than 18 years old and eligible adults with qualifying special needs;
- Expanding Minnesota's Child and Dependent Care Credit by increasing the income threshold at which the credit phaseout begins to $200,000 ($100,000 for married separate filers), increasing the percentage of expenses that qualify to 50% and increasing the maximum credit for care of young children under five years old;
- Updating the Child and Dependent Care Credit to allow single taxpayers to claim the "newborn credit" that is allowed for a child born in the tax year even if there are no eligible expenses; and
- Modifying the K-12 Education Credit to simplify the calculation and update the eligibility criteria to account for inflation. The update would increase the amount of income at which credit phaseout begins (from $33,500 to $59,210) and use federal adjusted gross income rather than household income when calculating the K-12 Education Credit.

Rationale/Background:

Child Tax Credit

Minnesota does not currently have a state-based Child Tax Credit (CTC) to support families with the costs of raising and caring for a child or eligible adult with qualifying special needs. The federal government has a partially refundable CTC and nine states have a refundable, state-based CTC.

The federal CTC is available for families with children who have employment income, but the program is not targeted to low-wage workers and provides greater benefit amounts for higher income families than for lower income families. The credit begins to phase out for income over $400,000 if Married Filing Jointly and $200,00 if filing as Single. The federal CTC was temporarily expanded in 2021 to remove the income requirement, increase the amount of the credit for lower-income households, and allow full refundability of the credit.

The availability of the federal and state refundable tax credits, and especially the expanded 2021 credit, has been shown to alleviate poverty for low- and middle-income families. The credit allows parents to afford basic essentials such as paying bills, paying for school expenses, investing in savings, and paying for childcare. There is a

strong relationship between childhood poverty and negative long-term outcomes. Reduction of poverty can result in better average birth weights and gestational ages, better parent-reported health status, and lower rates of child maltreatment.

The CTC is in addition to Minnesota's other tax benefits that are targeted to the costs of raising children – such as the K-12 Education Credit, the dependent deduction, and Dependent and Child Care Credit. The CTC would allow families to choose where the money would do the most good based on their financial situation. A state-based credit can fill in some of the gaps of the federal credit for lower-income families.

Child and Dependent Care Credit Expansion

Minnesota's Child and Dependent Care Credit is based on the federal Dependent Care Credit. The federal credit, which is nonrefundable, is equal to a percentage of unreimbursed employment-related expenses related to child or dependent care, up to $3,000 for one qualifying dependent and $6,000 for two or more qualifying dependents. Qualifying expenses are amounts paid for someone to care for your child or other dependent younger than age thirteen and household services. The credit rate depends on income and ranges from 35% for families with incomes of $15,000 or less to 20% for families with incomes over $43,000. The maximum federal credit is equal to $1,050 for one dependent and $2,100 for two or more dependents. The maximum qualifying expenses are reduced by the amount of the federal exclusion for employer-provided dependent care assistance.

The Minnesota Child and Dependent Care Credit is equal to the federal credit except that it is refundable and the maximum credit is phased out by 5% of adjusted gross income over a threshold ($59,210 in 2023). The credit is not available for individuals filing a married separate return. A newborn credit is allowed for a child born in the tax year even if there are not qualifying expenses. The newborn credit is only available to married taxpayers. Approximately 48,900 households claimed the Child and Dependent Care Credit in 2019.

K-12 Education Credit

Current law allows a taxpayer a refundable income tax credit equal to 75% of eligible education expenses for a qualifying child in kindergarten through 12th grade. The maximum credit is $1,000 for each child. Eligible expenses include fees for instruction outside the regular school day or school year, expenses for textbooks or instructional materials, and transportation costs paid to others. Tuition is not an eligible expense. A maximum of $200 per family for certain computer hardware and software is allowed. Approximately 28,300 households claimed this credit in 2019.

The maximum credit phases out starting at household income of $33,500. Household income includes income from all sources, both taxable and nontaxable. Taxpayers must use worksheets to make modifications to their adjusted gross income by adding in certain sources of income that are not included in the federal adjusted gross income amount on their return. This calculation of household income is then used to determine eligibility for the credit. This calculation can be complex and confusing for taxpayers, resulting in the need to assistance in preparing returns and mistakes.

For taxpayers with one child, the maximum credit decreases by $1 for every $4 of household income over $33,500. For taxpayers with two or more children, the maximum credit decreases by $2 for every $4 of household income over $33,500. The phaseout range increases by $2,000 for each additional child. The income thresholds are not indexed for inflation and were set at $33,500 when the credit was first effective in 1998.

Proposal:

Child Tax Credit

The Child Tax Credit is a state-based, fully refundable income tax credit. While the proposed credit is modeled on the components of the expanded portion of the 2021 federal CTC, it is a stand-alone credit that does not require a taxpayer to be eligible for the federal credit.

- The credit can be claimed for a child younger than 18 years of age or an eligible adult with qualifying special needs.
- The credit is equal to $1,000 per child
- The maximum total credit allowable in any year is $3,000.
- The maximum credit amount is phased-out by $100 for each $1,000 of federal adjusted gross income (FAGI) over the following thresholds: $50,000 if Married Filing Jointly, $25,000 if Married Filing Separately, and $33,300 if filing as Single or Head of Household.
- The credit does not require that the taxpayer have any minimum earned income, unlike the federal CTC**.**
- The credit is available for filers and children with either a Social Security Number or an Individual Taxpayer Identification Numbers (ITINs). ITINs are used only for the purpose of filing taxes. The IRS issues them to individuals who are not eligible for an SSN but are required to file taxes.
- The amount of credit, maximum credit, and income thresholds are indexed for inflation.

The credit would be effective for tax years 2023 through 2030.

Child and Dependent Care Credit Expansion

The proposal expands the credit to provide relief for the increasing costs of childcare. The percentage of qualifying expenses that can be included is increased to 50%. The threshold at which the credit begins to phaseout is increased to $200,000 ($100,000 for married separate filers). The percentage of costs are reduced by one percentage point for each $800 of adjusted gross income over $200,000 ($400 of AGI over $100,000 for married separate filers) until the percentage equals zero. The threshold is adjusted for inflation beginning in tax year 2024.

Taxpayers who care for their own child under the age of six at a licensed family day care home are deemed to have paid an amount equal to what they would charge to care for the child.

The maximum eligible expenses are increased for a young child under the age of five. The maximum is increased by $5,000 for one young child, $10,000 for two young children, and by $15,000 for three or more young children.

Children	**Maximum Eligible Expenses**	**Maximum Credit**
1 child	$3,000	$1,500
Under 5	$8,000	$4,000
2 children	$6,000	$3,000
One under 5	$11,000	$5,500
Two under 5	$16,000	$8,000
3 children	$6,000	$3,000
One under 5	$11,000	$5,500
Two under 5	$16,000	$8,000
Three under 5	$21,000	$10,500

The proposal also updates the credit to allow eligibility for the newborn credit for all filing statuses except married filing separately.

The Department of Human Services will incur systems costs as a result of this proposal. Systems changes are needed to add the expanded dependent care credit to the child support calculator used to determine how costs are split between parents.

K-12 Education Credit
This proposal phases out the credit using federal adjusted gross income (FAGI) rather than total household income. The phaseout threshold is increased to match the threshold for the state Child and Dependent Care Credit, which was set to be $59,210 in tax year 2023 (under current law.) The threshold is adjusted for inflation beginning in tax year 2024. The phaseout rates and maximum credit amount are unchanged. Using FAGI will greatly simplify the calculation of the credit and ability to file a return.

Impact on Children and Families:

A state-based CTC will add to the other vital tax benefits that Minnesota invests in to support families, including K-12 Education Credit and Subtraction, Child and Dependent Care Credit, and the Renters' and Homeowners' Property Tax Refund.

The CTC is an important source of financial stability for low- and moderate-income families with children. The credit is refundable, meaning it can provide refunds to families without any tax liability. Studies of the federal CTC have shown that families use these refunds to provide financial stability for the needs of the household, including health care costs, rent and utility payments, and educational costs.

With the rising cost of school supplies, the K-12 refundable credit provides relief to help families provide the necessary resources to children attending K-12 schools. The benefit helps make tutoring, extracurricular enrichment and other programs more accessible to families.

Access to extracurricular activities, tutors, school supplies, and computer software and hardware help set children up for success for life after high school. This proposal simplifies the calculation method and adjusts the threshold for the credit so that more children and families can access programs and resources that improve educational outcomes.

Equity and Inclusion:

The availability of the federal and state refundable tax credits, and especially the expanded 2021 federal child tax credit (CTC), has been shown to help alleviate poverty for low- and middle-income families. It helps parents afford basic essentials such as paying bills, paying for school expenses, investing in savings, and paying for childcare costs. Data on Minnesota families indicates that a significant percentage of children – particularly American Indian and African American children - live in low-income households, according to MN Compass. A state-based credit may help fill in some of the gaps of the federal credit for lower-income families by providing additional financial support to afford basic essentials for their families and children.

Expanded eligibility to the K-12 credit allows for more households to recoup some if not all, of the costs of educational opportunities for their children. By increasing the threshold amount to $59,210 in tax year 2023 to match the current threshold for the Child and Dependent Care Credit, parents and caretakers who would otherwise be unable to afford education expenses for tutoring, or school supplies, may be eligible to claim the credit.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Results:

- This proposal provides support for over 360,000 households that could claim an average Child Tax Credit of $1,500.
- This proposal triples the number of households that are eligible to claim the Child and Dependent Care Credit to approximately 157,600 households. The average credit would increase from $500 to over $1,500.
- This proposal will increase the number of households with a newborn that qualify for the Child and Dependent Care Credit. Under current law, about 3,800 returns will receive $2.1 million in newborn credits in tax year 2023, with an average credit of $550. Under this proposal, about 2,500 more returns will be eligible for the credit.
- This proposal increases the number of households that are eligible to claim the K-12 Education Credit. Some households will qualify for a larger tax credit than they would if impacted under the previous income phaseout. Changing the eligibility calculation to use adjusted gross income reduces complexity for taxpayers. This proposal allows approximately 29,600 more families to claim the K-12 refundable credit, with an average credit amount of $300.

Statutory Change(s):

Minnesota Statutes 2020, section 290.067, 290.0674, new section added to chapter 290.

FY 2024-25 Biennial Budget Change Item

Change Item Title: Ombudsperson for Long Term Care Staffing

Fiscal Impact ($000s)	FY 2024	FY 2025	FY 2026	FY 2027
General Fund				
Expenditures	$500	$500	$500	$500
Revenues				
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	$500	$500	$500	$500
Total FTEs	**4**	**4**	**4**	**4**

Recommendation:

The Governor recommends an increase of $1 million dollars for the FY 2024-2025 biennium and $1 million dollars for FY 2026-2027 and ongoing for the Office of Ombudsman for Long-Term Care (OOLTC). This is in addition to the current funding of $6.053 million dollars for the FY 24-25 biennium. The funding will support an increase in staffing levels which will improve the Office's ability to act as consumer advocates for those receiving long-term care services. Currently, the staff of the Office of Ombudsman for Long-Term Care are unable to fully meet the demand for services. The Governor recommends the addition of 4 full-time equivalents (FTEs) including 3 full-time regional ombudsman and one additional legal support staff.

Rationale/Background:

The Office of Ombudsman for Long-Term Care (OOLTC) is mandated by the Older Americans Act. The OOLTC is a program of the Minnesota Board on Aging and OOLTC is administratively housed in the Department of Human Services. The Office is currently staffed by 44 FTEs. The Office advocates for person-directed living, which respects individual values and preferences and preserves individual rights. Regional ombudsman work with long-term care consumers, nursing homes, assisted livings, hospitals, home care providers, social service agencies, and public agencies to enhance the quality of life and services for individuals receiving health care and supportive services. The Office's work includes, among other areas, addressing elder abuse in Minnesota's long-term care settings, protecting clients from retaliation, working to protect and expand resident rights, advocating for residents' choices, and providing information about long-term care regulations to consumers.

The ombudsman staff act as independent consumer advocates who investigate complaints, offer information and consultations, and advocate for changes to protect the health, safety, welfare, and rights of long-term care consumers. The service is free to the consumer. Any adult receiving long-term care services in Minnesota is eligible for assistance. The office provides advocacy in a wide variety of settings including nursing homes, the eight state-run veterans homes, boarding care homes, assisted livings, hospitals, hospice, Tribal Nations of MN, and settings where home care and customized living are provided.

Complaints investigated by the Office's regional ombudsmen can be initiated from a variety of sources including; consumers, family members, state agencies, primary health care providers, facility staff, etc. Regardless of who first contacts the OOLTC, the consumer is the client and provides direction to the regional ombudsman. The Office works to resolve care and rights complaints through negotiation, education, and referrals. The Office also

provides education about consumer rights to older and vulnerable adults, families, providers, and others, and works to intervene before concerning situations escalate.

The OOLTC currently has 25 regional ombudsmen serving in defined geographic regions statewide. The work of the regional ombudsmen is increasingly complex. Staffing shortages and related problems like a facility's inability to provide regular wound care or showers, improper medicine administration, and long-call wait times keep regional ombudsman very busy working on casework. Complaints across all categories rose by 16% from 2021 to 2022 and complaints about care problems rose 30%.

In addition to casework the regional ombudsmen are mandated to visit all 360 Minnesota nursing homes every quarter. The goal of these visits is to have a regular presence so that residents, family, and staff are aware of ombudsman services and to take action on any observable issues during the visit. Too often, visits are missed due to other complaint work. Of Minnesota's 360 skilled nursing facilities, 254, or 70% were visited every quarter in federal fiscal year 2022.

The Office prioritizes cases that increase housing stability and continuity of care. Complaints about transfer, discharge, and evictions from nursing homes and assisted livings almost doubled from 2021 to 2022. There are effective appeal rights that help give residents the opportunity to resolve issues and remain in their housing. Investigations of eviction, involuntary discharges, termination of services and improper transfers are complex problems to resolve in the best interest of the consumer. This work affects the amount of time regional ombudsmen are able to provide a regular presence in assisted livings around the state. As of fall 2022, regional ombudsmen have not visited nearly 1,000 of the 2,100 assisted living facilities licensed in Minnesota since August 1, 2021.

The addition of 3 regional ombudsman will allow the Office to have a broader reach and presence within all communities including underserved populations. Regional ombudsmen generally provide in-person service at the location where the resident lives and receives long-term care services and supports. This has many benefits including allowing the regional ombudsman to more easily verify concerns raised by the residents. Increased advocacy services prevents problems and improves quality of life and quality of care. More regional ombudsmen will reduce the geographic size of regions. This will allow for more in-person visits and less driving time between sites. Also, the additional staff will allow the OOLTC to target and expand services to Minnesotans receiving licensed home care in their own apartments and private homes. These clients have been an underserved community by the OOLTC.

The aging population continues to grow and more Minnesotans will be using the state's broad network of licensed long-term care options, so investments into the Office now will help Minnesotans for years to come.

Every state is mandated to have an Office of Ombudsman for Long-Term Care. Minnesota's Office currently has 25 regional ombudsman and seeks to grow to 28. This will bring the ratio of regional ombudsman to bed ratio from 6,625 beds per regional ombudsman down to a more manageable 5,915 beds per regional ombudsman. The Institute of Medicine (IOM) conducted a study of the Ombudsman for Long-Term Care Program. This study concluded the adequate number of regional Ombudsman staff to residents is 1 FTE to 2000.

Proposal:
OOLTC seeks an increase in funding to add 4 total positions. This expansion is needed in order to:

1. Permit more robust client service and investigation efforts: The addition of 3 FTE regional ombudsman staff will allow regional ombudsmen to have more time to work with individual consumers to prevent and resolve the consumers' long-term care complaints. Geographic regions will be smaller, drive times shorter, and there will be the ability to expand into more home care work. Regional ombudsman will go from serving roughly 6,625 beds per regional ombudsman to a more manageable 5,915 per region.
2. Ensure quality and compliance with federal and state standards: As the OOLTC grows, the staff who support the work of the regional ombudsman also must grow. One FTE to provide legal support to regional ombudsman as they represent consumers in administrative law appeals and to support the alignment of policies and procedures required in the office.

Impact on Children and Families:
OOLTC works with adults age 18 and over. Minnesotans who seek long-term care services have health needs which can create demands on caregivers and impact family systems. While the focus of the OOLTC is to serve the care recipient, regional ombudsmen do provide education, support, and referrals to caregivers and their families in the course of their work.

Equity and Inclusion:
OOLTC's work is focused on providing direct advocacy services to consumers of long-term care to help them improve their health care services and their quality of life. OOLTC works with adults of every income level and from all 87 counties in the state and Tribal Nations of MN.

Access to health care and housing stability are two of the strategic priorities in the One Minnesota Plan. The mission of One Minnesota Plan: "Improve the lives of all Minnesotans by working collaboratively to implement policies that achieve results." This mission is in alignment with the vision of the OOLTC: "All Minnesotans seeking or receiving long-term care services and supports have a high quality of life and high quality of care with a person-centered focus." All of the clients that we serve live with disabilities and are categorically vulnerable adults under Minnesota law.

Minnesotans who contact the OOLTC can be educated about their health care options. OOLTC staff advocate with facility social workers and others to ensure that residents can live in the least restrictive setting of their choice. The Office's advocacy helps residents achieve housing stability and continuity of care as we support residents to avoid contract terminations and facility discharges. Increasing the appropriation to the OOLTC ensures better access for the thousands of Minnesotans who qualify for and would benefit from OOLTC's advocacy services.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

IT Costs ($000s)
No IT costs are requested with this proposal.

Results:
This change request does not seek to change existing programs or activities or establish new ones.

Statutory Change(s):
N/A.

AT A GLANCE

- Conducts more than 11,000 administrative appeals per year (Average of FY18-FY21).
- Reviews and approves more than 1500 new contracts per year, not including amendments and purchase order revisions.
- Conducts more than 2200 eligibility reviews for DHS programs and services.
- Our Single Audit Coordinator monitors 188 subrecipients, following up on all findings related to major federal programs.
- The Internal Audits Office responds to approximately 600 hotline complaints per year.
- The Digital Forensics lab conducted analysis on over 800 devices and data sets and assisted with more than 40 search warrants in the last 12 months.
- Provides human resource management for about 7,140 state staff and about 4,100 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 7,140 DHS employees.
- Promotes continuous improvement and accountability across the 11 essential human services in all 87 counties.
- Licenses approximately 23,000 service providers.
- Conducts healthcare program integrity activities. CY2021 resulted in 228 healthcare provider investigations, more than $14.8 million in overpayments identified, and 255 administrative actions taken.
- Conducts child care program integrity activities. CY2021 resulted in 69 child care provider investigations, more than $484,000 in overpayments identified, and 12 administrative actions taken.
- Conducts recipient program integrity activities including fraud prevention grants for tribes and counties and involvement in over 17,0000 recipient investigations (CY 2021).
- Conducts background studies for more than 70 provider types, including more than 53,000 entities
- All funds spending for Operations activities for FY 2021 was $128 million. This represents 0.6% of the Department of Human Services overall budget.

PURPOSE AND 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, technology planning and facilities management. We also coordinate the agency's internal equity and anti-racism work.

Finally, we work to ensure the prudent use of public dollars by investigating, preventing, and stopping fraud, waste, and abuse of state and federal money.

SERVICES PROVIDED

Our **Compliance Office** is responsible for legal and compliance activities throughout the agency:

- The **Appeals Division** conducts administrative fair hearings for applicants and recipients appealing the denial, reduction, sanction or termination of benefits in cash and food programs, health care programs, social services programs and residential programs. We also hold administrative hearings when a state or county agency has determined a person committed program fraud, maltreated a child or vulnerable adult, or believes a person should be disqualified from having access to or working with vulnerable populations in a program licensed by the department.
- The **Contracts, Purchasing and Legal Compliance Division** is the agency wide facilitator of DHS goods and services acquisitions including agency-wide asset management, commodities procurements, professional and technical services, and 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 **Organizational Integrity Office** 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.

The Office for Employee Culture is responsible for the agency's human resources management, agency wide learning and development and employee engagement, change management, and diversity recruitment and retention. .

The **Management Services division** is 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 Strategy and Performance** (OSP) partners with executive leadership on strategic planning, data insights, evaluation, performance measurement, evaluation, and change management to drive improved outcomes for all served by DHS.

- The **Human Services Performance Management** unit works to improve counties service delivery performance in the Minnesota human services system by building connections, measuring and reporting performance, providing data-informed improvement assistance, advancing equity to reduce disparities, and advocating for system change.

- The **Enterprise Insight and Strategy** team supports DHS leadership's long-term planning and enterprise efforts in analytics, project management, and initiative implementation. Key services include leadership development, organizational design and change management, strategic planning, evaluation, research, and performance management.

The **DHS Office of Inspector General** (https://mn.gov/dhs/general-public/office-of-inspector-general/) manages financial fraud and abuse investigations; licenses and certifies programs for children and adults; and conducts background studies on people who apply to work in health and human services settings:

- Our Licensing Division (https://mn.gov/dhs/general-public/licensing/) licenses and certifies residential and nonresidential programs for children and vulnerable adults to ensure that the programs meet health and safety requirements and the law. These programs include child care centers, family child care (via counties), foster care (via counties), adoption agencies, children's residential facilities, and services for people with developmental disabilities, substance use disorders and mental illness. Our staff also complete investigations of maltreatment of vulnerable adults and children receiving services licensed by DHS.
- Our Background Studies Division (https://mn.gov/dhs/general-public/background-studies/) conducts background studies for people who provide care or have direct contact with people being served in certain health and human services programs, and for people who work in child care settings. Background studies determine whether a person has committed an act that would disqualify them from providing care, and help keep vulnerable populations safe. Our staff also complete background studies on others, such as people who are guardians or are planning to adopt a child.
- Our Financial Fraud and Abuse Investigations Division is responsible for program integrity activities for health care, economic assistance, child care assistance and food support programs to ensure that public programs are utilized for the delivery of high-quality, needed services free of fraud, waste and abuse.

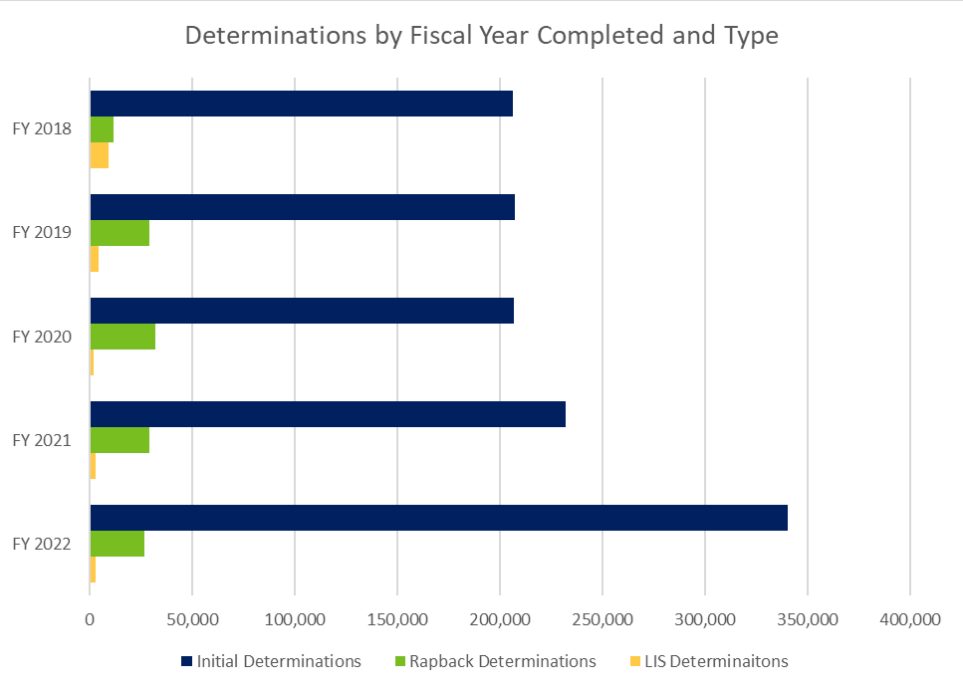
Our **Office of the Chief Financial Officer** provides fiscal services and controls the financial transactions of the agency, including the Central Office and Direct Care and Treatment. Core functions include preparing budget information, paying agency obligations, providing federal fiscal reporting, conducting patient revenue generation and collections, administering the Parental Fee program, processing agency receipts and preparing employees' payroll. The Reports and Forecasts Division (https://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.

The **Business Solutions Offices** works across the agency and with external stakeholders to partner with MNIT to provide integrated technology solutions that support and improve the delivery of human services by connecting services, information, and people to create a better, easier experience for everyone. Staff in this office develop the business architecture to support system solution design, serve as the business owners for enterprise applications, coordinate the submission of federal funding applications, align data strategies, work throughout the agency and with external stakeholders on business readiness efforts and implement governance oversight for the information management and technology work of the agency. All this work seeks to integrate the delivery of human services. For the people we serve this means creating an experience that is easy to navigate by aligning and simplifying programs, eligibility, and policies, using technology that people use in their daily lives to meet them where they are at, and providing one entry point for people to learn, access, and qualify for the breadth of programs and services available to them.

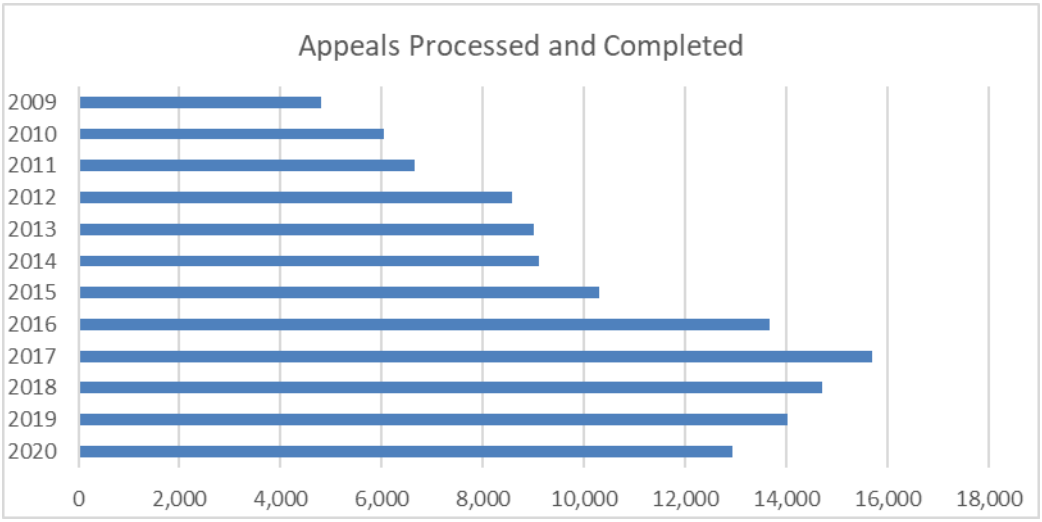
The **General Counsel's Office** provides legal advice, counsel, and direction for all of DHS' legal activities.

RESULTS

Number of background studies determinations completed each fiscal year.



Number of Appeals processed and completed by fiscal year



Operations' legal authority is in several places in state law: chapter 245C (Human Services Background Studies) and sections ; and chapters 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).

Statutes that give the agency authority to investigate fraud, waste, and abuse: 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).

Statutes that give the agency authority to conduct background studies: M.S. chapter 245C (Human Services Background Studies)and M.S. sections 144.057, 144A.476, and 524.5-118

Chapters authorizing the agency's work conducting licensing of human services providers and investigating reports related to maltreatment of minors and of vulnerable adults: M.S. chapters 245A (Human Services Licensing); 245D (Home and Community-Based Services Standards); 245F (Withdrawal Management Programs); 245G (Chemical Dependency Licensed Treatment Facilities); 245H (Certified License-Exempt Child Care Centers); 245I (Mental Health Uniform Service Standards Act); 260E (Reporting of Maltreatment of Minors); and M.S. Section 626.557 (Reporting of Maltreatment 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.

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	77,550	80,362	80,498	88,639	83,903	83,326	242,339	191,477
1200 - State Government Special Rev	4,163	4,176	4,058	4,290	4,174	4,174	5,182	5,450
1201 - Health Related Boards				522	279	459	279	459
2000 - Restrict Misc Special Revenue	6,267	6,565	7,105	12,920	13,713	13,713	14,283	14,319
2001 - Other Misc Special Revenue	27,154	27,402	26,210	31,228	27,908	27,010	27,908	27,010
2360 - Health Care Access	6,187	6,307	5,560	8,725	7,456	7,456	9,347	11,244
3000 - Federal	7,023	5,251	5,824	13,349	30,593	5,494	30,593	5,494
3001 - Federal TANF	3			100	100	100	100	100
3010 - Coronavirus Relief	2,625	1,009						
4925 - Paid Family Medical Leave							2,649	
Total	**130,972**	**131,072**	**129,255**	**159,773**	**168,126**	**141,732**	**332,680**	**255,553**
Biennial Change				26,984		20,830		299,205
Biennial % Change				10		7		104
Governor's Change from Base								278,375
Governor's % Change from Base								90
Expenditures by Category								
Compensation	80,907	83,583	83,622	91,581	111,484	85,658	144,130	126,619
Operating Expenses	49,216	46,798	45,272	68,184	56,586	56,018	187,442	128,878
Grants, Aids and Subsidies	191	67	141				1,052	
Capital Outlay-Real Property	217	209	18					
Other Financial Transaction	440	414	203	8	56	56	56	56
Total	**130,972**	**131,072**	**129,255**	**159,773**	**168,126**	**141,732**	**332,680**	**255,553**
Full-Time Equivalents	**753.14**	**738.19**	**726.95**	**726.35**	**760.07**	**738.01**	**1,086.60**	**1,100.75**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		1,412		5,681				
Direct Appropriation	154,469	151,391	177,263	172,826	166,282	166,017	324,718	274,168
Transfers In	22,153	30,091	16,937	14,540	7,729	7,729	7,729	7,729
Transfers Out	97,955	102,470	108,021	104,408	90,108	90,420	90,108	90,420
Cancellations		62						
Balance Forward Out	1,117		5,681					
Expenditures	**77,550**	**80,362**	**80,498**	**88,639**	**83,903**	**83,326**	**242,339**	**191,477**
Biennial Change in Expenditures				11,224		(1,908)		264,679
Biennial % Change in Expenditures				7		(1)		156
Governor's Change from Base								266,587
Governor's % Change from Base								159
Full-Time Equivalents	524.62	509.75	490.35	490.35	535.67	525.01	855.64	875.34
1200 - State Government Special Rev								
Balance Forward In		11		116				
Direct Appropriation	4,174	4,174	4,174	4,174	4,174	4,174	5,182	5,450
Cancellations		9						
Balance Forward Out	11		116					
Expenditures	**4,163**	**4,176**	**4,058**	**4,290**	**4,174**	**4,174**	**5,182**	**5,450**
Biennial Change in Expenditures				9		0		2,284
Biennial % Change in Expenditures				0		0		27
Governor's Change from Base								2,284
Governor's % Change from Base								27
Full-Time Equivalents	35.97	35.28	33.64	33.64	33.64	33.64	34.49	35.24
1201 - Health Related Boards								
Direct Appropriation			522		334	574	334	574
Transfers Out					55	115	55	115
Expenditures			**522**		**279**	**459**	**279**	**459**
Biennial Change in Expenditures			522			216		216
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								0

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1251 - COVID-19 Minnesota								
Direct Appropriation	10							
Balance Forward Out	10							
2000 - Restrict Misc Special Revenue								
Balance Forward In	3,754	784	1,431	2,564	3,602	3,847	3,602	3,847
Receipts	7,619	7,812	9,617	15,004	15,004	15,004	15,574	15,610
Transfers In	77	75	77	79	79	79	79	79
Transfers Out	4,412	742	1,456	1,125	1,125	1,125	1,125	1,125
Balance Forward Out	772	1,363	2,564	3,602	3,847	4,092	3,847	4,092
Expenditures	**6,267**	**6,565**	**7,105**	**12,920**	**13,713**	**13,713**	**14,283**	**14,319**
Biennial Change in Expenditures				7,193		7,401		8,577
Biennial % Change in Expenditures				56		37		43
Governor's Change from Base								1,176
Governor's % Change from Base								4
Full-Time Equivalents	66.28	63.59	64.15	64.15	81.33	79.72	81.33	79.72
2001 - Other Misc Special Revenue								
Balance Forward In	2,880	2,784	2,572	1,659	4,995	8,243	4,995	8,243
Receipts	23,880	27,724	38,064	35,643	32,235	31,337	32,235	31,337
Transfers In	12,778	11,712	679	679	679	679	679	679
Transfers Out	10,633	12,610	13,446	1,758	1,758	1,758	1,758	1,758
Balance Forward Out	1,751	2,207	1,659	4,995	8,243	11,491	8,243	11,491
Expenditures	**27,154**	**27,402**	**26,210**	**31,228**	**27,908**	**27,010**	**27,908**	**27,010**
Biennial Change in Expenditures				2,882		(2,520)		(2,520)
Biennial % Change in Expenditures				5		(4)		(4)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	55.48	59.58	65.09	65.09	46.49	37.95	46.49	37.95
2360 - Health Care Access								
Balance Forward In		46		1,269				

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Direct Appropriation	20,709	20,724	16,966	16,966	16,966	16,966	18,857	20,754
Transfers In		190						
Transfers Out	14,498	14,524	10,137	9,510	9,510	9,510	9,510	9,510
Cancellations		129						
Balance Forward Out	24		1,269					
Expenditures	**6,187**	**6,307**	**5,560**	**8,725**	**7,456**	**7,456**	**9,347**	**11,244**
Biennial Change in Expenditures				1,792		627		6,306
Biennial % Change in Expenditures				14		4		44
Governor's Change from Base								5,679
Governor's % Change from Base								38
Full-Time Equivalents	34.31	34.12	33.11	33.11	32.56	31.92	38.27	42.73

3000 - Federal

Balance Forward In	17			2	2	2	2	2
Receipts	7,006	5,251	5,826	13,349	30,593	5,494	30,593	5,494
Balance Forward Out			2	2	2	2	2	2
Expenditures	**7,023**	**5,251**	**5,824**	**13,349**	**30,593**	**5,494**	**30,593**	**5,494**
Biennial Change in Expenditures				6,900		16,914		16,914
Biennial % Change in Expenditures				56		88		88
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	36.42	35.87	40.61	40.01	29.51	28.92	29.51	28.92

3001 - Federal TANF

Balance Forward In	31	0	0					
Receipts	3			100	100	100	100	100
Balance Forward Out	31	0	0					
Expenditures	**3**			**100**	**100**	**100**	**100**	**100**
Biennial Change in Expenditures				97		100		100
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	0.06				0.87	0.85	0.87	0.85

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
3010 - Coronavirus Relief								
Direct Appropriation	2,625	1,009						
Expenditures	**2,625**	**1,009**						
Biennial Change in Expenditures				(3,634)		0		0
Biennial % Change in Expenditures				(100)				
Governor's Change from Base								0
Governor's % Change from Base								
4925 - Paid Family Medical Leave								
Direct Appropriation							2,649	
Expenditures							**2,649**	
Biennial Change in Expenditures				0		0		2,649
Biennial % Change in Expenditures								
Governor's Change from Base								2,649
Governor's % Change from Base								

Program: Central Office Operations
Activity: Children & Families

https://mn.gov/dhs/people-we-serve/children-and-families/economic-assistance/income/programs-and-services/

AT A GLANCE

- Provides child support services to more than 314,000 custodial and non-custodial parents and 220,000 children annually.
- Provides child care assistance to an average of 29,000 children per month.
- 1,719 children were either adopted or had a permanent transfer of legal custody to a relative in 2021.
- Facilitates Supplemental Nutrition Assistance Program (SNAP) payments to more than 445,000 Minnesotans every month.
- All funds Children and Families administrative spending for FY 2021 was $65 million. This represented 0.3 percent of the Department of Human Services budget.

PURPOSE AND CONTEXT

Children and Families oversees and provides administrative support to counties, Tribal Nations, and social service agencies for child safety and well-being services and for economic assistance programs serving families and children. These services help ensure that 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
- Increase access to high quality child care

Our statewide administration of these programs ensures that 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
- Management Operations

In the Children and Families Services Administration our staff provides administrative direction and supports to counties, Tribal Nations, and community agencies. Our work includes:

- Researching, recommending and implementing statewide policy and programs
- Managing grants
- Providing training and technical assistance to counties, Tribal Nations, and grantees
- Evaluating and auditing service delivery
- Conducting quality assurance reviews to ensure that services are delivered effectively, efficiently and consistently across the state

Our areas of responsibility include administering several forecasted programs: the Minnesota Family Investment Program (MFIP), Diversionary Work Program (DWP), and MFIP Child Care Assistance. Our staff also support grant programs that fund 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 correctly determined. 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 2021, more than 1,000 county and tribal staff attended virtual classroom trainings and nearly 5,300 county and tribal staff completed online trainings provided by Children and Families staff on SNAP, family cash assistance, and child care assistance. Our staff also support our county and tribal partners to ensure eligibility is determined accurately and benefits are issued timely for the millions of dollars in benefits issued each month.

Funding for our programs comes from a combination of state and federal sources. Major federal block grants 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 $497 million in fiscal year 2021, including additional federal stimulus funds in response to the COVID-19 pandemic.

RESULTS

We provide administrative support to a broad array of programs and services for low-income families and adults and children.

Key Measures for programs serving families and children:

Type of Measure	***Description of Measure***	***2017***	***2018***	***2019***	***2020***	***2021***
Quality	Percent of children not experiencing repeated abuse or neglect within 12 months of a prior report	91.0%	91.0%	93.8%	94.5%	94.2%
Quality	Percent of all children who enter foster care in the previous year that are discharged to permanency (i.e., reunification with parents, caregivers, living with relative, guardianship, adoption) within 12 months	47.5%	48.6%	49.5%	46.0%	48.7%
Quality	Percent of all children in foster care who had been in care between 12 and 23 months on the first day of the year that were discharged to permanency within 12 months of the first day of the year	51.2%	58.9%	55.5%	52.4%	54.3%
Quality	Percent of all children in foster care who had been in care for 24 months or more on the first day of the year that were discharged to permanency within 12 months of the first day of the year	28.8%	34.0%	33.3%	32.4%	37.7%

Data for quality measures provided by the Children and Family Services Administration at the Department of Human Services.

The two key measures in MFIP/DWP are:

- The **Self-Support Index**, which is a results measure. The Self-Support Index 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 following chart 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***
2018	64.6%
2019	64.4%
2020	65.7%
2021	64.6%

- The federal Work Participation Rate (WPR) is a process measure and counts the number of parents engaging in a minimum number of hours of federally-recognized work activities. The measure does not count households who discontinue assistance when getting a job.

Federal Fiscal Year	***WPR***
2017	38.9%
2018	37.2%
2019	35.7%
2020	22.3%

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. NOTE: The Diversionary Work Program (DWP) was suspended due to COVID-19 during the state peacetime emergency from April 2020 to August 2021.

Calendar Year	***Median Placement Wage Per Hour for MFIP Clients***	***Median Placement Wage Per Hour for DWP Clients***
2018	$12.00	$12.50
2019	$13.00	$13.00
2020	$14.00	
2021	$15.00	

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	11,490	12,143	12,876	16,267	14,083	14,089	38,137	38,978
2000 - Restrict Misc Special Revenue	205	318	139	272	95	95	95	95
2001 - Other Misc Special Revenue	28,772	31,368	34,052	39,713	33,553	33,215	33,617	33,247
2005 - Opiate Epidemic Response							277	321
3000 - Federal	15,972	22,394	25,291	82,710	56,402	69,555	56,402	69,555
3001 - Federal TANF	2,468	2,467	2,230	2,582	2,582	2,582	3,572	3,676
3010 - Coronavirus Relief	2,589	1,319						
Total	**61,495**	**70,010**	**74,588**	**141,544**	**106,715**	**119,536**	**132,100**	**145,872**
Biennial Change				84,627		10,119		61,840
Biennial % Change				64		5		29
Governor's Change from Base								51,721
Governor's % Change from Base								23
Expenditures by Category								
Compensation	39,162	40,418	46,070	54,170	53,418	53,188	75,300	76,919
Operating Expenses	21,197	28,560	27,689	82,584	48,637	61,875	52,140	64,480
Grants, Aids and Subsidies	1,120	951	823	4,767	4,637	4,450	4,637	4,450
Other Financial Transaction	16	82	5	23	23	23	23	23
Total	**61,495**	**70,010**	**74,588**	**141,544**	**106,715**	**119,536**	**132,100**	**145,872**
Total Agency Expenditures	61,495	70,010	74,588	141,544	106,715	119,536	132,100	145,872
Internal Billing Expenditures	(8)	20	2					
Expenditures Less Internal Billing	**61,503**	**69,990**	**74,586**	**141,544**	**106,715**	**119,536**	**132,100**	**145,872**
Full-Time Equivalents	**365.60**	**363.99**	**387.29**	**386.58**	**455.81**	**446.05**	**569.09**	**563.65**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		216		2,102				
Direct Appropriation	13,948	14,814	18,685	18,760	18,791	18,797	42,909	43,718
Transfers In	3,168	4,350	2,323	2,532	915	915	915	915
Transfers Out	5,449	7,130	6,030	7,127	5,623	5,623	5,687	5,655
Cancellations		107						
Balance Forward Out	177		2,102					
Expenditures	**11,490**	**12,143**	**12,876**	**16,267**	**14,083**	**14,089**	**38,137**	**38,978**
Biennial Change in Expenditures				5,510		(971)		47,972
Biennial % Change in Expenditures				23		(3)		165
Governor's Change from Base								48,943
Governor's % Change from Base								174
Full-Time Equivalents	93.60	94.09	95.50	95.50	111.96	112.45	219.46	223.95
2000 - Restrict Misc Special Revenue								
Balance Forward In	396	334	596	618	492	497	492	497
Receipts	53	1,083	95	79	33	33	33	33
Transfers In	41	62	67	67	67	67	67	67
Transfers Out		630						
Balance Forward Out	285	532	618	492	497	502	497	502
Expenditures	**205**	**318**	**139**	**272**	**95**	**95**	**95**	**95**
Biennial Change in Expenditures				(112)		(221)		(221)
Biennial % Change in Expenditures				(21)		(54)		(54)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	1.14	1.29	1.30	0.75	0.40	0.39	0.40	0.39
2001 - Other Misc Special Revenue								
Balance Forward In	1,487	1,726	1,874	1,212	74	59	74	59
Receipts	6,521	20,210	28,938	33,300	28,263	27,940	28,263	27,940
Transfers In	22,021	11,724	4,453	5,275	5,275	5,275	5,339	5,307
Transfers Out	645	1,333						
Balance Forward Out	612	960	1,212	74	59	59	59	59
Expenditures	**28,772**	**31,368**	**34,052**	**39,713**	**33,553**	**33,215**	**33,617**	**33,247**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Biennial Change in Expenditures				13,626		(6,997)		(6,901)
Biennial % Change in Expenditures				23		(9)		(9)
Governor's Change from Base								96
Governor's % Change from Base								0
Full-Time Equivalents	148.52	145.59	147.29	147.29	148.59	144.35	148.59	144.35

2005 - Opiate Epidemic Response

Direct Appropriation							277	321
Expenditures							**277**	**321**
Biennial Change in Expenditures			0		0			598
Biennial % Change in Expenditures								
Governor's Change from Base								598
Governor's % Change from Base								
Full-Time Equivalents							2.00	2.00

3000 - Federal

Balance Forward In	128	131	182	45	45	45	45	45
Receipts	15,870	22,311	25,153	82,710	56,402	69,555	56,402	69,555
Transfers In	50							
Balance Forward Out	76	48	45	45	45	45	45	45
Expenditures	**15,972**	**22,394**	**25,291**	**82,710**	**56,402**	**69,555**	**56,402**	**69,555**
Biennial Change in Expenditures				69,634		17,956		17,956
Biennial % Change in Expenditures				182		17		17
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	106.10	105.20	129.33	129.19	179.60	173.91	179.60	173.91

3001 - Federal TANF

Balance Forward In	184	182						
Receipts	2,284	2,285	2,230	2,582	2,582	2,582	3,572	3,676
Expenditures	**2,468**	**2,467**	**2,230**	**2,582**	**2,582**	**2,582**	**3,572**	**3,676**
Biennial Change in Expenditures				(124)		352		2,436
Biennial % Change in Expenditures				(3)		7		51
Governor's Change from Base								2,084
Governor's % Change from Base								40

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Full-Time Equivalents	16.24	16.50	13.85	13.85	15.26	14.95	19.04	19.05

3010 - Coronavirus Relief

Balance Forward In		713						
Direct Appropriation	2,644	1,197						
Transfers In		79						
Cancellations		670						
Balance Forward Out	55							
Expenditures	**2,589**	**1,319**						
Biennial Change in Expenditures				(3,908)		0		0
Biennial % Change in Expenditures				(100)				
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents		1.32	0.02					

AT A GLANCE

- **Medical Assistance** provided coverage for an average of 1,188,285 people each month during FY 2021.
- **MinnesotaCare** provided coverage for an average of 92,912 people each month during FY 2021.
- In FY 2021, our Health Care Consumer Support team received 252,190 telephone calls from recipients.
- In FY 2021, our Provider Call Center received 229,253 calls from providers.
- All funds administrative spending for the Health Care activity for FY 2021 was $92.8 million. This represents 0.04 percent of the Department of Human Services overall budget.

PURPOSE AND CONTEXT

The Minnesota Department of Human Services (DHS) Health Care Administration administers the following two health care programs for low-income Minnesotans:

Medical Assistance (MA) is 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 dependent children.

MinnesotaCare provides coverage for those who do not have access to affordable health care coverage but whose income is too high for Medical Assistance.

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 Minnesota Health Care Programs (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, and;
- 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, and;
- Coordinating the development of recommendations on health care policy and legislation.

Health Care Eligibility Operations

- Processes paper applications for MinnesotaCare and the Minnesota Family Planning Program,
- Provides ongoing case maintenance and processes changes in enrollee circumstance that may influence eligibility,
- Provides in-person and online training, responds to system-related questions from counties and tribes, and provides systems support, and;
- Operates the Health Care Consumer Support team (member help desk) and responds to enrollee phone calls regarding eligibility, covered services, and provider availability.

Health Care Eligibility and Access

- Administers all eligibility policy for the Medical Assistance and MinnesotaCare programs including long term care services;
- Provides policy support for county social service agencies, tribal governments, and other entities processing applications for MHCP;
- Conducts disability determinations to determine Medical Assistance eligibility under a disability basis via the State Medical Review Team (SMRT), and;
- Develops business requirements for eligibility systems including MAXIS, Medicaid Management Information System (MMIS), and the Minnesota Eligibility Technology System (METS).

Purchasing and Service Delivery (PSD)

- Coordinates the purchasing and delivery of services in state health care programs and administers coverage and benefit policies;
- Establishes payment policies and calculations for fee-for-service and managed care rates, and;
- Negotiates and manages annual contracts between DHS and managed care organizations.

Medicaid Payments and Provider Services (MPPS)

- Supports MHCP members and providers, conducts benefits recovery and claims processing, runs the provider call center, enrolls health care providers, and manages all provider training and communication regarding the health care programs;
- 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;
- Ensures the timely and accurate payment of health care services, and;
- Operates the Provider Call Center and responds to provider phone calls regarding member eligibility, enrollment, billing, coverage policies, and payment.

Health Care 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, and;
- Uses heath care claims data to inform policy and program development and monitors the quality of health care services purchased by DHS.

HCA staff shares some health care coverage policy and rates development functions with the Behavioral Health, Housing, Deaf and Hard of Hearing (BHDH) Administration and the Aging and Disability Services Administration (ASDA) for the services under the purview of those other administrations.

HCA 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, and;
- Hold managed care plans accountable for health equity outcomes related to depression, diabetes, and well child visits.

RESULTS

DHS works to make Minnesota 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 enrollees in Minnesota's public health care programs.

As part of Minnesota's commitment to deliver quality health care more effectively, DHS 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. This nation-leading reform effort has saved $465.5 million in health care costs between 2013 and 2020, and continues to show how financial incentives and value-based payment can lower costs, maintain or improve health care quality and outcomes, and lead to innovative methods of delivering health care and other services tailored to a specific community's needs. Providers participating in the program currently serve more than 470,000 Minnesotans.

In 2010, DHS was directed to develop and implement a demonstration testing alternative health care delivery systems, including accountable care organizations (ACOs). This led to the development of the Integrated Health Partnerships (IHP) program in 2013. The goal of the program is to improve the quality and value of care provided to Medicaid and MinnesotaCare enrollees while lowering the cost through innovative approaches to care and payment.

The program allows participating providers to enter into an arrangement with DHS to care for enrollees under a payment model that holds the participants accountable for the costs and quality of care their Medicaid patients receive. Providers who participate work together to better coordinate and manage care, resulting in better outcomes.

IHP providers have experienced better health outcomes for their Medicaid and MinnesotaCare populations; for example, they had readmissions rates that were 4 percent lower and emergency department visits that were 2.5 percent lower than the IHP comparable population in 2019, and, according to preliminary data, continued to outperform non-IHP providers in 2020. IHPs also perform better than other Medicaid providers on several quality measures. For example, on outcomes measures related to diabetes, asthma, and vascular care, IHPs perform significantly better than other providers. Further, while a provider's Medicaid population typically shows worse outcomes than their commercial population on these metrics, this gap is narrower for the population served by the IHPs. Finally, IHPs also perform better than other providers on ensuring adolescents are screened for mental health issues. Those IHPs with explicit behavioral health focused interventions have shown high levels of relative improvement since 2017, with typical year-to-year relative improvement of 30 percent to 40 percent.

The IHP program continues to expand. Providers that deliver care for less than the targeted cost are eligible to share in the savings; some providers also share the downside risk if costs are higher than targeted. As IHPs progress into their second and third contract years, a portion of their payment is tied to their performance on quality metrics.

In 2020, the most recent period with a final performance calculation, IHP savings to the health care system totaled more than $27.5 million. This comes on top of savings of $7.55 million in 2019, $105.9 million in 2018, $107 million in 2017, $49.5 million in 2016, $87.5 million in 2015, $65.3 million in 2014 and $14.8 million in 2013. These savings are shared by providers, managed care organizations, the federal government, and the state.

Beginning in 2018, DHS expanded and enhanced the IHP model in several important ways. DHS introduced multiple tracks to accommodate a diverse set of provider systems, added a quarterly population-based payment to providers to support their care coordination and infrastructure needs, modified the quality measurements methodology, and increased accountability for nonmedical social factors affecting the health of and disparities found within the IHP population. As part of the accountability model tied to this population-based payment, IHPs are required to implement and evaluate specific initiatives that address a variety of social risk factors that impact the health of their patients and/or community. These innovative initiatives include programs that address food insecurity, unmet mental health needs, housing insecurity, the health needs of individuals recently released from jail or prison, and other social determinants of health.

Type of Measure	***Name of Measure***	***Previous***	***Current***	***Dates***
Quality	Percent of electronically submitted claims paid within two days[1]	98.59%	98.52%	FY2019 and FY2021
Quantity	Number of Integrated Health Partnerships[2]	26	27	2020 and 2021
Quantity	Total MA Benefit Recoveries (excluding fraud and cost avoidance)[3]	$61.6 million	$55.8 million	FY2019 and FY2021

Performance Measure Notes:

1. Source: FY 2021 Member and Provider Services Operational Statistics. Compares Fiscal year 2019 (Previous) to Fiscal year 2021 (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 provider systems or collaboratives of independent practices voluntarily contracting with DHS as an IHP to serve MA and MinnesotaCare recipients. Compares 2020 (Previous) to 2021 (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 2019 (Previous) and FY 2021 (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)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	18,431	17,277	18,160	30,825	21,763	20,952	54,776	35,580
2000 - Restrict Misc Special Revenue	1,305	1,371	1,756	2,598	2,598	2,598	2,598	2,598
2001 - Other Misc Special Revenue	56,061	52,714	48,974	56,714	50,632	50,349	50,632	50,349
2360 - Health Care Access	28,347	27,657	26,767	31,569	28,168	28,168	28,168	28,168
3010 - Coronavirus Relief	591	192						
Total	**104,735**	**99,212**	**95,657**	**121,706**	**103,161**	**102,067**	**136,174**	**116,695**
Biennial Change				13,416		(12,135)		35,506
Biennial % Change				7		(6)		16
Governor's Change from Base								47,641
Governor's % Change from Base								23
Expenditures by Category								
Compensation	66,835	64,891	65,442	75,230	64,030	63,364	83,910	73,809
Operating Expenses	37,652	34,180	30,149	46,329	38,938	38,677	52,071	42,860
Grants, Aids and Subsidies	188	103	63	128	167		167	
Capital Outlay-Real Property			0					
Other Financial Transaction	59	38	3	19	26	26	26	26
Total	**104,735**	**99,212**	**95,657**	**121,706**	**103,161**	**102,067**	**136,174**	**116,695**
Total Agency Expenditures	104,735	99,212	95,657	121,706	103,161	102,067	136,174	116,695
Internal Billing Expenditures				18	18	18	18	18
Expenditures Less Internal Billing	**104,735**	**99,212**	**95,657**	**121,688**	**103,143**	**102,049**	**136,156**	**116,677**
Full-Time Equivalents	**715.64**	**658.72**	**642.97**	**642.97**	**554.09**	**537.42**	**715.34**	**599.67**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		920		6,686				
Direct Appropriation	22,769	23,820	26,397	26,038	23,614	22,803	56,627	37,431
Transfers In	1,730	1,169	721	697				
Transfers Out	5,321	8,063	2,272	2,596	1,851	1,851	1,851	1,851
Cancellations		569						
Balance Forward Out	747		6,686					
Expenditures	**18,431**	**17,277**	**18,160**	**30,825**	**21,763**	**20,952**	**54,776**	**35,580**
Biennial Change in Expenditures				13,276		(6,270)		41,371
Biennial % Change in Expenditures				37		(13)		84
Governor's Change from Base								47,641
Governor's % Change from Base								112
Full-Time Equivalents	120.23	92.11	92.62	92.62	99.01	93.79	260.26	156.04
2000 - Restrict Misc Special Revenue								
Balance Forward In		19	0					
Receipts	855	948	1,132	1,983	1,983	1,983	1,983	1,983
Transfers In	466	404		615	615	615	615	615
Transfers Out			(624)					
Balance Forward Out	16							
Expenditures	**1,305**	**1,371**	**1,756**	**2,598**	**2,598**	**2,598**	**2,598**	**2,598**
Biennial Change in Expenditures				1,678		842		842
Biennial % Change in Expenditures				63		19		19
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	8.34	5.31	7.56	7.56	5.32	5.22	5.32	5.22
2001 - Other Misc Special Revenue								
Balance Forward In	6,020	2,869	6,953	2,602	2,653	3,254	2,653	3,254
Receipts	3,193	33,940	42,284	54,084	48,552	48,269	48,552	48,269
Transfers In	54,579	18,198	2,437	2,709	2,709	2,709	2,709	2,709
Transfers Out	6,442	100	98	28	28	28	28	28
Balance Forward Out	1,288	2,193	2,601	2,653	3,254	3,855	3,254	3,855
Expenditures	**56,061**	**52,714**	**48,974**	**56,714**	**50,632**	**50,349**	**50,632**	**50,349**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Biennial Change in Expenditures				(3,086)		(4,707)		(4,707)
Biennial % Change in Expenditures				(3)		(4)		(4)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	288.69	285.18	279.18	279.18	225.84	218.95	225.84	218.95

2360 - Health Care Access

Balance Forward In		104		3,401				
Direct Appropriation	25,063	24,406	30,168	28,168	28,168	28,168	28,168	28,168
Transfers In	3,700	3,776						
Transfers Out	400	190						
Cancellations		438						
Balance Forward Out	16		3,401					
Expenditures	**28,347**	**27,657**	**26,767**	**31,569**	**28,168**	**28,168**	**28,168**	**28,168**
Biennial Change in Expenditures				2,332		(2,000)		(2,000)
Biennial % Change in Expenditures				4		(3)		(3)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	298.38	276.12	263.61	263.61	223.92	219.46	223.92	219.46

3010 - Coronavirus Relief

Direct Appropriation	591	192						
Expenditures	**591**	**192**						
Biennial Change in Expenditures				(783)		0		0
Biennial % Change in Expenditures				(100)				
Governor's Change from Base								0
Governor's % Change from Base								

Program: Central Office Operations
Activity: Aging and Disability Services

https://mn.gov/dhs/people-we-serve/seniors/

AT A GLANCE

- Covered Disability Waiver home and community-based services for 55,797 people per month in FY21.
- Covered Personal Care Assistance (PCA) services for 38,866 people per month in FY21.
- Covered nursing facility services for 12,219 people per month in FY21.
- Covered Elderly Waiver and Alternative Care services for 27,032 people per month in FY21.
- Performs statewide human services planning and develops and implements policy.
- Obtains, allocates, and manages resources, contracts, and grants.
- Senior Nutrition grants provide congregate dining to 20,400 people and home delivered meals to 24,000 people.
- Provides comprehensive assistance and individualized help to more than 134,000 individuals through over 280,000 calls in 2021 through the Senior LinkAge Line®.
- 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.
- Provided 4,221 people living with HIV/AIDS medical and support services in FY21.
- In FY 2021, lead agencies administered over 187,000 assessments for long-term services and supports. (This includes MnCHOICES, legacy LTCC and DD screenings, and PCA Assessments)
- Administer $68.14 million of grants to providers under Aging and Adult Services grants, $79.20 million under Disability Grants and $33.10 million under Other Long Term Care grants in FY21.
- All funds administrative spending for the Aging and Disability Services Administration activity for FY21, before Disability Services joined the Administration, was $20.82 million. This represented 0.10 percent of the Department of Human Services overall budget.

PURPOSE AND CONTEXT

The Aging and Disability Services Administration administers Minnesota's publicly funded long-term care programs and services for Minnesotans who are aging and/or have a disability 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 of the individuals we serve;
- Manage an equitable and sustainable long-term care system that maximizes value;
- Continuously improve how we administer services; and
- Promote professional excellence and engagement in our work.

SERVICES PROVIDED

The Aging and Disability Services Administration is composed of the following Divisions and units, each charged with particular areas of responsibility:

- Aging and Adult Services Division;
- Disability Services Division;
- Fiscal Analysis and Results Management;
- Nursing Facility Rates and Policy Division;
- Operations and Central Functions; and
- Planning and Aging 2030.

Our work includes:

- Administering Medical Assistance long-term services and supports 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.
- Working with the Community Supports Administration to administer the Moving Home Minnesota program, a federal Money Follows the Person Rebalancing Demonstration Program which serves 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 program evaluation and measuring results using lead agency waiver reviews.
- Staffing of the Governor-appointed Minnesota Board on Aging (https://mn.gov/board-on-aging/), a state board 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;
- Providing legislative coordination with the department, legislature and stakeholders;
- Supporting both Continuing Care for Older adults and Community Supports administrations on IT modernization projects, IT project portfolio oversight, and business process improvement efforts; and
- Providing outreach, staff support and technical assistance to stakeholders and stakeholder workgroups; and
- Auditing 354 nursing facility annual cost reports to ensure DHS and providers are maintaining compliance with federal and state requirements and timely publication of accurate payment rates.
- Administer programs to assure access to services, facilitate community engagement, provide technical assistance on best practices, develop local service capacity, and provide general program oversight and guidance.
- Promote access to core medical and support services to people living with HIV/AIDS by paying premiums to maintain private insurance, co-payments for HIV-related medications, mental health services, dental services, nutritional supplements, and case management.
- 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.
- Secure funding outside of state appropriations and seek such opportunities to leverage goals.

- Developing an assisted living report card to inform Minnesota consumers and support assisted living quality improvement, including a public website with quality ratings that is scheduled to be released in the fall of 2023.

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, assistance resolving issues with Medicare and prescription drugs, connections with volunteer opportunities, or help finding 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.

In addition, starting in March 2020, additional work is being conducted to address the COVID-19 pandemic:

- The Board on Aging received directly allocated funding from the federal Coronavirus Act, Relief, and Economic Security (CARES) act. The funding will mainly be used food security for home-bound for older adults who have disabilities, multiple chronic illnesses, and caregivers of older adults. Additional funding includes funding for the Office of Ombudsman for Long-Term Care. The Board also received funding from the Administration for Community Living for the Senior LinkAge Line and Disability HUB to provide critical access functions to serve populations most at risk of COVID-19. The total funding available for these funds is about $13.888 million and is available until September 30, 2021.
- In addition, $11.3 million was received from the Coronavirus Relief Fund for senior meals throughout the state and $1.063 million for an enhanced homecare benefit. This funding expires December 31, 2020.
- Under state law governing disasters (Minn. Stat. sec. 12A.10), DHS administers expedited reimbursement to nursing facilities to support efforts to limit COVID-19 exposure and to prevent the spread of COVID-19 within facilities. Costs that are eligible for expedited reimbursement are those necessary to ensure the health and safety of residents during the COVID-19 federal emergency declaration including PPE, additional staff hours and wages, and staff testing costs. The expedited reimbursement program began in March 2020 and will be available up to 60 days following the termination of the COVID-19 federal emergency declaration.

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. Average statewide risk-adjusted nursing facility quality of care score out of a possible 100 points	68.0	68.9	Jan. 2018 to Dec. 2021
Result	2. Percent of older adults served by home and community-based services	72.8%	79.1%	FY 2017 to FY 2021
Result	3. Difference between total weighted average daily payment rate as reported on the cost reports and the published rate.	Reported: $248.34 Published: $246.12 % Change: -1% MA Impact: ($11M)	Reported: $265.94 Published: $261.40 % Change: -2% MA Impact: ($22M)	CY 2018 to CY2019
Result	4. Annual total of net nursing facility audit adjustments to reported costs	40.3M	37.4M	CY 2020 to CY 2021
Result	5. Percent of working age adults on certain Medical Assistance programs earning $600 or more per month	18% (FY2019)	16% (FY2021)	FY 2017 to FY 2019
Result	6. Percent of people with disabilities who receive home and community-based services at home.	60.2% (FY2017)	63.2% (FY2021)	2017 to 2021
Result	7. Percent of long term service and support spending for people with disabilities in home and community-based services rather than institutions.	90.1% (FY2017)	94.5% (FY2021)	2017 to 2021

More information is available on the Long-Term Service and Support Performance Dashboards (https://mn.gov/dhs/ltss-program-performance).

Performance Notes:

1. Measure one compares data from the one year period January through December 2018, to data from the one year period January through December 2021. (Source: Minimum Data Set resident assessments)
2. This measure shows the percentage of older adults receiving publicly-funded long-term services and supports who receive home and community-based services through the Elderly Waiver, Alternative Care, or home care programs instead of nursing home services. (Source: DHS Data Warehouse)
3. Nursing facility daily payment rates are based on an annual cost report filed by facilities. The Nursing Facility Rates and Policy division audits these reports in order to ensure accuracy. The difference between reported and published rates in this measure represents corrections made a result of these audits. Without these audits, payment rates and MA payments would be higher. (Source: Nursing Facility Rates and Policy Division)
4. This measure represents audit adjustments to annual nursing facility cost reports. (Source: Nursing Facility Rates and Policy Division)
5. Measure compares monthly earnings for people age 18-64 who receive services from one of the following Medical Assistance programs: Home and Community-Based Waiver Services, Mental Health Targeted Case Management, Adult Mental Health Rehabilitative Services, Assertive Community Treatment and Medical

Assistance for Employed Persons with Disabilities (MA-EPD). More information is also available on the Employment First Dashboard (mn.gov/dhs/employment-first-dashboards)Source: DHS Data Warehouse.

6. This measure compares people who receive disability waiver services in their own home rather than residential services. More information is available on the Long-Term Service and Support Performance Dashboards (mn.gov/dhs/ltss-program-performance). Source: DHS Data Warehouse.
   This measure compares spending of long term service and support for people with disabilities in home and community-based services rather than institutions. More information is available on the Long-Term Service and Support Performance Dashboards (mn.gov/dhs/ltss-program-performance). 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 Continuing Care for Older Adults, we list legal citations that apply to the program at the end of each budget narrative.

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	14,045	13,843	18,812	27,806	38,726	34,688	52,800	53,916
1200 - State Government Special Rev	125	124	125	125	125	125	125	125
2000 - Restrict Misc Special Revenue	138	229	146	187	187	187	187	187
2001 - Other Misc Special Revenue	2,078	1,816	1,599	4,829	3,564	3,360	3,564	3,360
2403 - Gift				15	15	15	15	15
3000 - Federal	3,282	4,823	4,970	7,926	11,292	10,820	11,292	10,820
3010 - Coronavirus Relief	471	1,509	2,310					
Total	**20,139**	**22,345**	**27,960**	**40,888**	**53,909**	**49,195**	**67,983**	**68,423**
Biennial Change				26,365		34,256		67,558
Biennial % Change				62		50		98
Governor's Change from Base								33,302
Governor's % Change from Base								32
Expenditures by Category								
Compensation	14,368	15,712	16,674	22,152	34,246	33,177	43,459	46,689
Operating Expenses	5,574	6,556	11,168	18,691	19,628	15,983	24,489	21,699
Grants, Aids and Subsidies	166	55	98	10				
Capital Outlay-Real Property			0					
Other Financial Transaction	32	21	20	35	35	35	35	35
Total	**20,139**	**22,345**	**27,960**	**40,888**	**53,909**	**49,195**	**67,983**	**68,423**
Total Agency Expenditures	20,139	22,345	27,960	40,888	53,909	49,195	67,983	68,423
Internal Billing Expenditures	22		3	27	27	27	27	27
Expenditures Less Internal Billing	**20,117**	**22,345**	**27,957**	**40,861**	**53,882**	**49,168**	**67,956**	**68,396**
Full-Time Equivalents	**131.07**	**139.70**	**144.07**	**150.20**	**293.15**	**278.25**	**362.40**	**369.50**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		3,606		3,960				
Direct Appropriation	18,703	19,297	23,017	23,997	38,726	34,688	52,800	53,916
Transfers In	1,456	2,623	233	473				
Transfers Out	3,026	7,143	318	624				
Cancellations		4,540	160					
Balance Forward Out	3,088		3,961					
Expenditures	**14,045**	**13,843**	**18,812**	**27,806**	**38,726**	**34,688**	**52,800**	**53,916**
Biennial Change in Expenditures				18,730		26,796		60,098
Biennial % Change in Expenditures				67		57		129
Governor's Change from Base								33,302
Governor's % Change from Base								45
Full-Time Equivalents	95.85	103.44	107.66	108.33	247.48	233.51	316.73	324.76
1200 - State Government Special Rev								
Direct Appropriation	125	125	125	125	125	125	125	125
Cancellations		1						
Balance Forward Out			0					
Expenditures	**125**	**124**	**125**	**125**	**125**	**125**	**125**	**125**
Biennial Change in Expenditures				0		0		0
Biennial % Change in Expenditures				0		0		0
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	1.03	0.95	0.99	0.99	1.08	1.06	1.08	1.06
1251 - COVID-19 Minnesota								
Balance Forward In		10						
Direct Appropriation	10							
Cancellations		10						
Balance Forward Out	10							
2000 - Restrict Misc Special Revenue								
Balance Forward In	4,960	458	344	225	225	225	225	225
Receipts	111	115	26	187	187	187	187	187

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Transfers Out	4,475							
Balance Forward Out	458	344	224	225	225	225	225	225
Expenditures	**138**	**229**	**146**	**187**	**187**	**187**	**187**	**187**
Biennial Change in Expenditures				(34)		41		41
Biennial % Change in Expenditures				(9)		12		12
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	1.70	1.92	1.21	1.21	1.57	1.54	1.57	1.54

2001 - Other Misc Special Revenue

Balance Forward In	122	5,823	6,640	8,781	8,241	7,986	8,241	7,986
Receipts	203	500	1,050	1,713	633	409	633	409
Transfers In	7,559	1,833	2,689	2,576	2,676	2,764	2,676	2,764
Transfers Out		34						
Balance Forward Out	5,807	6,305	8,780	8,241	7,986	7,799	7,986	7,799
Expenditures	**2,078**	**1,816**	**1,599**	**4,829**	**3,564**	**3,360**	**3,564**	**3,360**
Biennial Change in Expenditures				2,534		496		496
Biennial % Change in Expenditures				65		8		8
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	6.65	8.00	7.51	7.51	1.94		1.94	

2403 - Gift

Balance Forward In	16	16	16	16	16	16	16	16
Receipts	0	0	0	15	15	15	15	15
Balance Forward Out	16	16	16	16	16	16	16	16
Expenditures				**15**	**15**	**15**	**15**	**15**
Biennial Change in Expenditures				15		15		15
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								0

3000 - Federal

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Balance Forward In	25	12	378	250	250	250	250	250
Receipts	3,266	4,823	4,841	7,926	11,292	10,820	11,292	10,820
Balance Forward Out	9	12	250	250	250	250	250	250
Expenditures	**3,282**	**4,823**	**4,970**	**7,926**	**11,292**	**10,820**	**11,292**	**10,820**
Biennial Change in Expenditures				4,791		9,216		9,216
Biennial % Change in Expenditures				59		71		71
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	25.84	24.49	26.67	32.16	41.08	42.14	41.08	42.14

3010 - Coronavirus Relief

Balance Forward In			4,420					
Direct Appropriation	471	8,657						
Cancellations		3,300	2,110					
Balance Forward Out		3,848						
Expenditures	**471**	**1,509**	**2,310**					
Biennial Change in Expenditures				330		(2,310)		(2,310)
Biennial % Change in Expenditures				17				
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents		0.90	0.03					

3015 - ARP-State Fiscal Recovery

Direct Appropriation			100					
Cancellations			100					

Program: Central Office Operations
Activity: Behavioral Health, Housing, and Deaf & Hard of Hearing Services

https://mn.gov/dhs/people-we-serve/

AT A GLANCE

- Statewide, there were 33,315 individuals on Minnesota in Medicaid Programs treated for substance use disorder in CY21.
- In FY21, the Housing Support program served a monthly average of 21,896 people.
- Received funding for Home and Community Based Federal Financial Participation in the 2021 Legislative session. Both Operational and Grant funds were received.
- 612 individuals who are deaf, deafblind, and hard of hearing statewide were served by Deaf and Hard of Hearing Services Grants in FY21.
- 12,400 Minnesota adults received mental health services through Minnesota Health Care Programs (MHCP) in CY21.
- In FY2021, the Minnesota Supplemental Aid program supported a monthly average of 32,467 people.
- An average of 20,559 participants were provided services monthly by the Housing Support Program in FY21.
- All funds administrative spending for the Community Supports Budget Activity for FY21 was $23 million. This represented 0.02% of the Department of Human Services overall budget.

PURPOSE AND CONTEXT

The Behavioral Health, Housing and Deaf & Hard of Hearing Services Administration (BHDH) within the Department of Human Services oversees service delivery systems for people with behavioral health problems, people who are deaf, deafblind and hard of hearing, and people needing housing and income supports. This includes prevention, treatment, long-term services and supports, including home and community-based services, other Medical Assistance benefits specialized grant programs.

BHDH 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.

BHDH 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 four divisions within the Behavioral Health, Housing and Deaf & Hard of Hearing Services Administration (BHDH):

- Behavioral Health Division (combination of former Alcohol and Drug Abuse and Mental Health Divisions)
- Deaf and Hard of Hearing Services Division
- Housing Supports Division
- Central Operations Division

Our administration also houses and provides administrative support infrastructure to the independent Minnesota Commission for Deaf, Deafblind and Hard of Hearing.

Collaborating both with partners within state agencies and in local communities, our administration shapes and implements public policy on mental health, substance use disorder treatment and prevention services, home and community based services, services for people who are deaf, deafblind and hard of hearing and housing supports.

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 substance use disorder.
- Administer payment policy and manage grant programs for mental health and substance use disorder services, such as the Consolidated Chemical Dependency Treatment Fund, Minnesota Health Care Programs, Adult Mental Health Grants, Child Mental Health Grants and Substance Use Disorder Treatment Support Grants.
- Administer programs to assure access to services, facilitate community engagement, provide technical assistance on best practices, develop local service capacity, and provide general program oversight and guidance.
- 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, including the Governor-appointed Commission of Deaf, DeafBlind and Hard of Hearing, 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.
- 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	The number of adults receiving Assertive Community Treatment (ACT) services..	2,013	2,051	CY2020 vs. CY2021
Quantity	1. Number of children in the child welfare system who received a mental health screeing..[1]	7,617	6,408	CY 019 vs. CY2020
Result	2. Percent of clients in DHHS grant-funded mental health programs who completed or are making good progress on their treatment plan goals. .[2]	91%	82%	2019 vs. 2021
Quantity	3. Number of Adults with Serious Mental Illness who received Adult Rehabilitative Mental Health Services (ARMHS).[3]	19,429	19,776	CY 2020 to CY 2021

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Result	4. 11th grade use of alcohol, 1-2 days, during the past 30 days..[4]	14%	13%	FY2019 to FY2021
Quality	5. Percent of consumers in DHHS grant-funded programs who are satisfied with quality of services they received.[5]	82%	82%	FY2019 to FY2021

Performance Measure Notes:

1. Percent of children reiving a mental health screening: This activitiy 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..
2. Source: Consumer satisfaction surveys and grantee reports..
3. Source: DHS Data Warehouse.
4. The use of alcohol use measures consists of data reported in the Minnesota Student Survey.
5. Data source: Consumer satisfaction surveys and grantee reports.

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)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	30,991	30,780	33,382	51,999	22,296	19,858	35,108	36,445
2000 - Restrict Misc Special Revenue	4,575	6,995	6,793	8,810	8,352	8,352	8,352	8,352
2001 - Other Misc Special Revenue	5,603	5,080	5,913	8,339	4,243	3,899	4,243	3,899
2005 - Opiate Epidemic Response		103	185	794	699	639	765	705
2403 - Gift				3				
3000 - Federal	7,652	7,368	5,993	14,845	11,957	8,386	11,957	8,386
3010 - Coronavirus Relief	1,054	405						
3015 - ARP-State Fiscal Recovery			68	427				
4800 - Lottery	101	95	76	250	163	163	163	163
Total	**49,976**	**50,827**	**52,410**	**85,467**	**47,710**	**41,297**	**60,588**	**57,950**
Biennial Change				37,074		(48,870)		(19,339)
Biennial % Change				37		(35)		(14)
Governor's Change from Base								29,531
Governor's % Change from Base								33
Expenditures by Category								
Compensation	38,694	38,691	39,904	52,068	30,724	27,925	38,506	38,709
Operating Expenses	8,051	9,879	10,307	30,007	15,163	10,668	20,259	16,537
Grants, Aids and Subsidies	3,081	2,203	2,055	3,319	1,760	2,641	1,760	2,641
Capital Outlay-Real Property			0					
Other Financial Transaction	150	53	145	73	63	63	63	63
Total	**49,976**	**50,827**	**52,410**	**85,467**	**47,710**	**41,297**	**60,588**	**57,950**
Total Agency Expenditures	49,976	50,827	52,410	85,467	47,710	41,297	60,588	57,950
Internal Billing Expenditures	(5)		14					
Expenditures Less Internal Billing	**49,981**	**50,827**	**52,397**	**85,467**	**47,710**	**41,297**	**60,588**	**57,950**
Full-Time Equivalents	**359.00**	**348.44**	**350.62**	**356.24**	**222.67**	**237.08**	**283.67**	**301.08**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In	213	1,955	411	9,015				
Direct Appropriation	36,031	35,772	41,767	42,996	22,412	19,974	35,224	36,561
Receipts	59	59	59	59	59	59	59	59
Transfers In	429	120	1,586	3,076				
Transfers Out	4,213	6,550	1,426	3,147	175	175	175	175
Cancellations		167						
Balance Forward Out	1,528	409	9,016					
Expenditures	**30,991**	**30,780**	**33,382**	**51,999**	**22,296**	**19,858**	**35,108**	**36,445**
Biennial Change in Expenditures				23,610		(43,227)		(13,828)
Biennial % Change in Expenditures				38		(51)		(16)
Governor's Change from Base								29,399
Governor's % Change from Base								70
Full-Time Equivalents	239.36	222.66	230.98	232.89	115.83	136.96	176.83	200.96
2000 - Restrict Misc Special Revenue								
Balance Forward In	24,530	1,303	2,444	2,727	3,181	1,929	3,181	1,929
Receipts	1,132	954	1,327	2,182	1,985	1,985	1,985	1,985
Transfers In	5,698	6,820	7,240	7,110	7,110	7,110	7,110	7,110
Transfers Out	25,656	27	1,491	28	1,995	743	1,995	743
Balance Forward Out	1,129	2,056	2,727	3,181	1,929	1,929	1,929	1,929
Expenditures	**4,575**	**6,995**	**6,793**	**8,810**	**8,352**	**8,352**	**8,352**	**8,352**
Biennial Change in Expenditures				4,034		1,101		1,101
Biennial % Change in Expenditures				35		7		7
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	39.45	38.57	41.71	41.91	41.41	40.59	41.41	40.59
2001 - Other Misc Special Revenue								
Balance Forward In	365	1,619	252	1,083	590	590	590	590
Receipts	1,267	1,552	4,522	5,492	1,889	1,545	1,889	1,545
Transfers In	4,946	3,013	2,421	2,469	2,469	2,469	2,469	2,469
Transfers Out	115	874	199	115	115	115	115	115
Balance Forward Out	860	229	1,083	590	590	590	590	590

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures	**5,603**	**5,080**	**5,913**	**8,339**	**4,243**	**3,899**	**4,243**	**3,899**
Biennial Change in Expenditures				3,569		(6,110)		(6,110)
Biennial % Change in Expenditures				33		(43)		(43)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	30.57	32.15	30.73	30.73	15.72	12.61	15.72	12.61

2005 - Opiate Epidemic Response

Direct Appropriation		309	309	794	699	639	765	705
Cancellations		206	124					
Expenditures		**103**	**185**	**794**	**699**	**639**	**765**	**705**
Biennial Change in Expenditures				876		359		491
Biennial % Change in Expenditures						37		50
Governor's Change from Base								132
Governor's % Change from Base								10
Full-Time Equivalents		0.94	1.00	1.00	3.34	2.76	3.34	2.76

2403 - Gift

Balance Forward In	11	11	11	12	9	9	9	9
Receipts	0	0	0					
Balance Forward Out	11	11	11	9	9	9	9	9
Expenditures				**3**				
Biennial Change in Expenditures				3		(3)		(3)
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								

3000 - Federal

Balance Forward In	11							
Receipts	7,642	7,369	5,993	14,845	11,957	8,386	11,957	8,386
Balance Forward Out		0	0					
Expenditures	**7,652**	**7,368**	**5,993**	**14,845**	**11,957**	**8,386**	**11,957**	**8,386**
Biennial Change in Expenditures				5,818		(495)		(495)

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Biennial % Change in Expenditures				39		(2)		(2)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	48.54	53.06	44.92	47.26	45.04	42.85	45.04	42.85

3010 - Coronavirus Relief

Balance Forward In			7					
Direct Appropriation	1,054	533						
Cancellations		120	7					
Balance Forward Out		7						
Expenditures	**1,054**	**405**						
Biennial Change in Expenditures				(1,459)		0		0
Biennial % Change in Expenditures				(100)				
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents		0.06						

3015 - ARP-State Fiscal Recovery

Balance Forward In				327				
Direct Appropriation			395	100	0	0	0	0
Balance Forward Out			327					
Expenditures			**68**	**427**				
Biennial Change in Expenditures				495		(495)		(495)
Biennial % Change in Expenditures						(100)		(100)
Governor's Change from Base								0
Governor's % Change from Base								
Full-Time Equivalents			0.48	1.65				

4800 - Lottery

Balance Forward In		62		87				
Direct Appropriation	163	163	163	163	163	163	163	163
Cancellations		129						
Balance Forward Out	62		87					

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures	**101**	**95**	**76**	**250**	**163**	**163**	**163**	**163**
Biennial Change in Expenditures				129		0		0
Biennial % Change in Expenditures				66		0		0
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	1.08	1.00	0.80	0.80	1.33	1.31	1.33	1.31

Program: Central Office Operations
Activity: Central IT

https://mn.gov/mnit/about-mnit/who-we-are/

AT A GLANCE

- Connect over 2.8 million Minnesotans with access to vital DHS programs with the support of over 31,000 county, tribal, and state workers; 200,000 providers; client assistors; and DHS and MNsure partners via nearly 400 IT applications
- Oversee approximately 750 IT employees
- Manage around 70 active IT projects
- Total all funds spending for this budget activity in FY22 was $245 million, which represents approximately 1.5 percent of the agency budget.

PURPOSE AND CONTEXT

The Central IT budget activity funds Minnesota IT Services (MNIT) support for the Department of Human Services (DHS) to provide IT solutions that support agency business goals, and build and maintain the computer applications that automate the delivery of agency programs. MNIT provides secure and cost-effective information technology systems that support individuals who participate in DHS social services, health care, public assistance and direct care programs across the state. The work of MNIT helps DHS meet their mission to provide essential services to Minnesota's most vulnerable residents.

Please refer to the Office of MNIT Services Agency Profile for more information about the central MNIT organization.

SERVICES PROVIDED

MNIT provides the following services to DHS:

1. Leadership and planning support in the delivery of IT services to DHS at a high-value and cost-effective manner. This includes:
    - Implementation and participation in the DHS IT governance structure which allocates funding and guides IT program design, including the sequence/prioritization of IT work
    - Ensure that user experience design, accessibility and plain language are incorporated into DHS technology solutions
2. Program management activities to develop and operate the DHS IT project and portfolio management. This includes:
    - Portfolio and project management,
    - Business architecture,
    - Business analysis, and
    - Quality assurance

3. Application development and support to automate and maintain DHS services and operations. This includes:
    - Enterprise architecture,
    - Release management,
    - Methodologies to determine technology solutions,
    - Programming and coding, and
    - Ongoing maintenance to help ensure availability of DHS IT systems, and 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:
    - Cyber security,
    - Desktop, server and network support,
    - Operations support,
    - Firewall support & incident management,
    - Contact center support, and
    - Telephony, telepresence support

MNIT support provided for 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

MNIT 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 delivering technology solutions in order connect the people of MN to services provided by DHS, in order to support the DHS mission, vision, and values.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	New projects added to the Project Portfolio	13 projects added in FY2021*	24 projects added through June 2022*	Ongoing
Quantity	Projects completed	28 projects completed in FY2021*	24 projects completed through June 2022*	Ongoing

**MNIT has been working with DHS to review and reduce the size of the project portfolio to enable better oversight and management, and ultimately, faster completion for priority projects.*

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)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
2001 - Other Misc Special Revenue	219,273	206,080	221,034	249,811	179,928	164,130	179,928	164,130
Total	**219,273**	**206,080**	**221,034**	**249,811**	**179,928**	**164,130**	**179,928**	**164,130**
Biennial Change				45,492		(126,787)		(126,787)
Biennial % Change				11		(27)		(27)
Governor's Change from Base								0
Governor's % Change from Base								0
Expenditures by Category								
Operating Expenses	219,151	206,100	220,661	249,811	179,928	164,130	179,928	164,130
Grants, Aids and Subsidies		(58)						
Capital Outlay-Real Property	84		332					
Other Financial Transaction	38	38	40					
Total	**219,273**	**206,080**	**221,034**	**249,811**	**179,928**	**164,130**	**179,928**	**164,130**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
2001 - Other Misc Special Revenue								
Balance Forward In	16,893	38,859	42,387	12,518	11,361	11,361	11,361	11,361
Receipts	187,610	100,591	66,878	134,108	72,798	62,871	72,798	62,871
Transfers In	201,597	195,400	124,286	114,546	107,130	107,502	107,130	107,502
Transfers Out	184,246	114,400						
Balance Forward Out	2,582	14,370	12,518	11,361	11,361	17,604	11,361	17,604
Expenditures	**219,273**	**206,080**	**221,034**	**249,811**	**179,928**	**164,130**	**179,928**	**164,130**
Biennial Change in Expenditures				45,492		(126,787)		(126,787)
Biennial % Change in Expenditures				11		(27)		(27)
Governor's Change from Base								0
Governor's % Change from Base								0

Program: Forecasted Programs
Activity: MFIP Diversionary Work Program

https://mn.gov/dhs/people-we-serve/children-and-families/economic-assistance/income/programs-and-services/

AT A GLANCE

- About 70 percent of people served through the Minnesota Family Investment Program (MFIP) and Diversionary Work Program (DWP) are children.
- In an average month, the programs serve about 68,000 children and their parents or caretakers in almost 26,000 households.
- Families receive an average of $1,047 a month of a combined cash assistance and food support through MFIP and $481 a month of cash assistance through the Diversionary Work Program.
- All funds spending for the MFIP/DWP activity for FY 2021 was $376 million. This represented 1.9 percent of the Department of Human Services overall budget.

PURPOSE AND CONTEXT

MFIP and DWP provide temporary financial support to help meet the basic needs of low-income families with children and low-income pregnant women.

Most parents enrolling in MFIP or DWP were employed in the three months before they turned to the program for assistance. The majority are workers in one of four industries: hotel/restaurant, retail, temp agencies, and health care. Another significant portion of families receiving assistance have many barriers to stable employment including serious mental illness, chronic and incapacitating illness, or intellectual or developmental disabilities.

The goal of these 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 and federal Supplemental Nutrition Assistance Program (SNAP) funds and federal Temporary Assistance for Needy Families (TANF) funds. Counties and Tribal Nations administer the MFIP and DWP programs.

SERVICES PROVIDED

The Minnesota Family Investment Program provides job counseling, cash assistance, and food assistance. Families cannot receive assistance for more than 60 months in their lifetime, unless a significant impairment identified in state law qualifies them for extended assistance. The amount of assistance is based on family size and other sources of income. A family of three with no other income can receive $641 in cash assistance and $548 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. Families may also be eligible for childcare assistance and for health care coverage under Medical Assistance. Most families are also eligible for the MFIP housing assistance grant of $110 per month if they do not already receive a rental subsidy through the federal Department of Housing and Urban Development.

The Diversionary Work Program is a four-month long program for families who are applying for cash assistance who have not received cash assistance in the last 12 months and who meet other eligibility criteria. The program includes intensive, up-front job search services. A family receives cash benefits based on its housing, utility costs, and personal needs up to the same maximum as the Minnesota Family Investment Program, 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 $641 in financial assistance. Most families are also eligible for SNAP benefits, childcare assistance, and health care coverage under Medical Assistance.

RESULTS

The two key measures in MFIP are:

- The **Self-Support Index** is a results measure. The Self- Support Index gives the percentage of adults eligible for MFIP or DWP during a given 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*
2010	67.0%
2011	65.2%
2012	65.3%
2013	66.9%
2014	68.5%
2015	68.8%
2016	68.0%
2017	65.9%
2018	64.6%
2019	64.4%
2020	65.7%
2021	64.6%

- The federal **Work Participation Rate** (WPR) is a process measure and counts the number of parents engaging in a minimum number of hours of federally recognized work activities. The measure does NOT count households who discontinue assistance when getting a job.

Federal Fiscal Year	*WPR*
2010	40.2%
2011	43.9%
2012	45.3%
2013	45.1%
2014	46.2%
2015	37.9%
2016	39.4%
2017	38.9%
2018	37.2%
2019	35.7%
2020	22.3%

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)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	91,486	144,678	164,694	76,870	82,202	85,800	82,573	88,250
2000 - Restrict Misc Special Revenue				750	750	750	750	750
3000 - Federal	118,640	187,733	169,718	109,497	409,497	409,497	409,497	409,497
3001 - Federal TANF	59,873	43,547	13,899	88,820	104,923	105,315	105,337	109,974
Total	**269,999**	**375,959**	**348,312**	**275,937**	**597,372**	**601,362**	**598,157**	**608,471**
Biennial Change				(21,709)		574,485		582,379
Biennial % Change				(3)		92		93
Governor's Change from Base								7,894
Governor's % Change from Base								1
Expenditures by Category								
Grants, Aids and Subsidies	269,593	375,492	347,854	275,137	596,572	600,562	597,357	607,671
Other Financial Transaction	407	467	457	800	800	800	800	800
Total	**269,999**	**375,959**	**348,312**	**275,937**	**597,372**	**601,362**	**598,157**	**608,471**

MFIP Diversionary Work Program

Activity Financing by Fund

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Direct Appropriation	91,486	144,678	164,694	76,870	82,202	85,800	82,573	88,250
Expenditures	**91,486**	**144,678**	**164,694**	**76,870**	**82,202**	**85,800**	**82,573**	**88,250**
Biennial Change in Expenditures				5,400		(73,562)		(70,741)
Biennial % Change in Expenditures				2		(30)		(29)
Governor's Change from Base								2,821
Governor's % Change from Base								2
2000 - Restrict Misc Special Revenue								
Balance Forward In		147	386	600	600	600	600	600
Receipts	145	239	213	750	750	750	750	750
Balance Forward Out	145	386	600	600	600	600	600	600
Expenditures				**750**	**750**	**750**	**750**	**750**
Biennial Change in Expenditures				750		750		750
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								0
3000 - Federal								
Balance Forward In		574	680					
Receipts	118,647	187,839	169,038	109,497	409,497	409,497	409,497	409,497
Balance Forward Out	7	680						
Expenditures	**118,640**	**187,733**	**169,718**	**109,497**	**409,497**	**409,497**	**409,497**	**409,497**
Biennial Change in Expenditures				(27,158)		539,779		539,779
Biennial % Change in Expenditures				(9)		193		193
Governor's Change from Base								0
Governor's % Change from Base								0
3001 - Federal TANF								
Balance Forward In	54,372	97,476	138,262	230,094	224,907	210,384	224,907	208,980
Receipts	98,271	85,076	96,115	83,633	90,400	90,400	89,410	89,306
Balance Forward Out	92,769	139,004	220,478	224,907	210,384	195,469	208,980	188,312
Expenditures	**59,873**	**43,547**	**13,899**	**88,820**	**104,923**	**105,315**	**105,337**	**109,974**
Biennial Change in Expenditures				(701)		107,519		112,592

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Biennial % Change in Expenditures				(1)		105		110
Governor's Change from Base								5,073
Governor's % Change from Base								2

Program: Forecasted Programs
Activity: MFIP Child Care Assistance

https://mn.gov/dhs/people-we-serve/children-and-families/economic-assistance/child-care/programs-and-services/child-care-assistance.jsp

AT A GLANCE

- In 2021 MFIP Child Care Assistance paid childcare for 10,815 children in 5,173 families during an average month.
- The average monthly assistance per family was $1,754.
- All funds spending for the MFIP Child Care Assistance activity for FY 2021 was $114 million. This represented 0.6 percent of the Department of Human Services overall budget.

PURPOSE AND CONTEXT

In order to work, families need safe and reliable childcare. The annual cost of full-time care for one child ranges from $9,000 to $19,000 per year, depending on the age of the child, location, and type of provider attended. Many low-income families struggle to find affordable childcare that fits their needs. Minnesota Family Investment Program (MFIP) Child Care Assistance provides financial subsidies to help low-income families pay for childcare. To support quality childcare 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 support to help improve outcomes for the most at-risk children and their families by increasing access to high quality childcare.

The following families are eligible to receive MFIP childcare assistance or Transition Year childcare 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) childcare 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

When family income increases, the amount of childcare expenses paid by the family in the form of copayments also increases. All families receiving childcare 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 ($24,978) would have a total biweekly childcare provider payment of $25 for all children in childcare.

The MFIP childcare 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: childcare centers, family childcare, and legal non-licensed childcare. Providers are paid at the rate they charge private pay families up to the maximum rate. The program pays a higher rate to providers who meet quality standards through Parent Aware, are accredited, or hold certain educational credentials.

Childcare must be provided by a legal childcare provider over the age of 18 years. Allowable providers include legal non-licensed family childcare, license-exempt centers, licensed family childcare, and licensed childcare centers. Families choose their providers in the private childcare market. Counties administer the Child Care Assistance Program.

All families who meet eligibility requirements may receive this help. MFIP childcare 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.

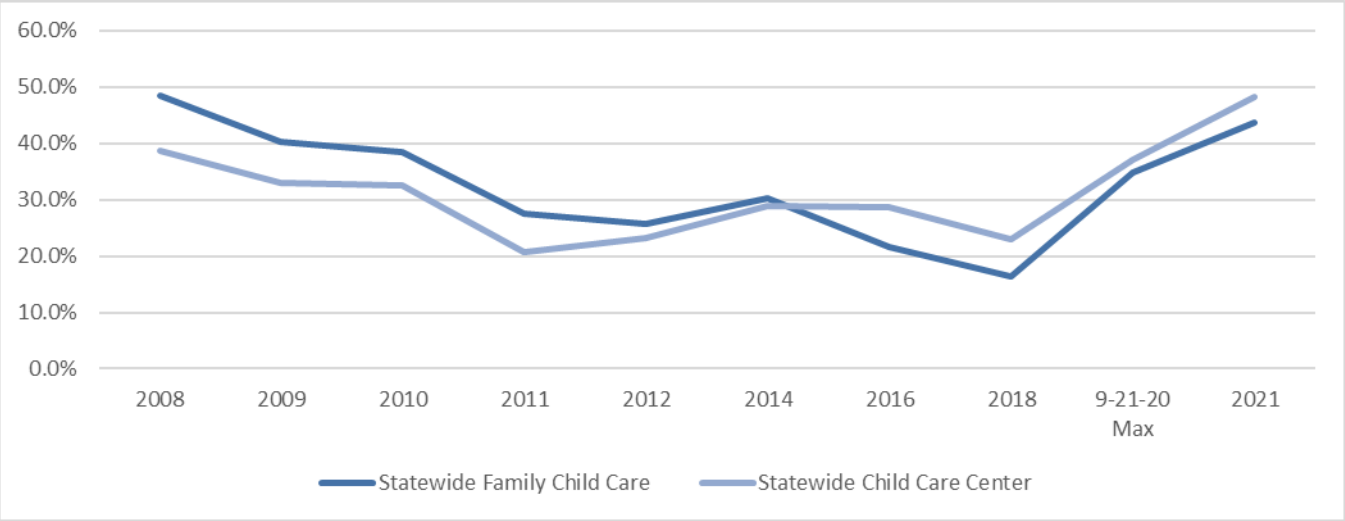
Various measures were taken during the Governor's Peacetime Emergency Declaration to address the impact of the coronavirus (COVID-19) pandemic. For example, the Commissioner approved a waiver temporarily allowing payments to closed childcare providers for up to one month. Another waiver allowed childcare assistance payments to a second childcare provider when a child's regular program temporarily closed or was unavailable.

RESULTS

Percent of provider prices fully covered by childcare - Maximum rates paid to providers under the Child Care Assistance Program may not cover the full cost of childcare. 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 childcare provider prices that are fully covered by the Child Care Assistance Program increased when the maximum rates were raised in the 2021 legislative session, but the maximum rate paid remains low compared to prices in the market.

This quality measure shows approximately 43 percent of family childcare providers and approximately 48 percent of childcare centers charge prices that are fully covered by the Child Care Assistance Program maximum rates.

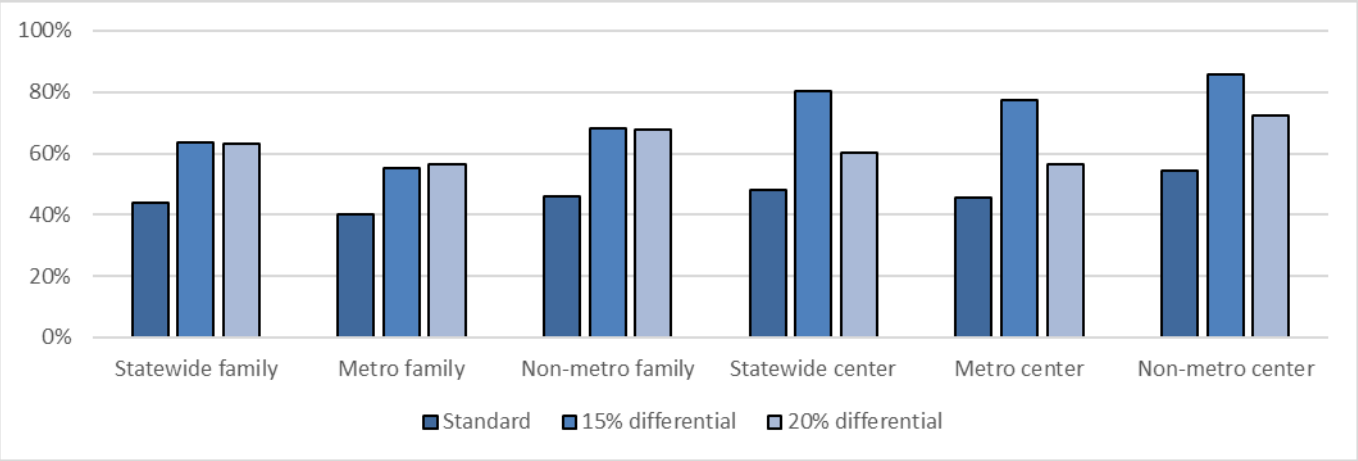
Provider prices fully covered by Standard Maximum Rates statewide, by percent



Quality Differential Impact- Parent Aware is Minnesota's rating tool for helping parents select high quality childcare and early education programs. The Child Care Assistance Program allows for a maximum rate up to 15 percent higher for providers with a Parent Aware 3-star rating, or who hold certain accreditation or education standards established in statute. An up to 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.

Prices fully covered by Standard and Quality Differential Maximum Rates, by percent (November 2021)



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 at a higher proportion compared to 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 childcare assistance through providers eligible for the higher subsidy rates for quality has increased from 37.5 percent in July of 2016 to 52 percent in July of 2021.

Percent of Children Receiving Child Care Assistance in Quality Settings

	2018	2019	2020	2021
Standard Care	57.7%	51.6%	46.6%	44.5%
Provider holds Accreditation*	3.2%	2.8%	2.4%	2.4%
Provider holds Parent Aware 1-2 Star	5.7%	6.3%	4.0%	3.5%
Provider holds Parent Aware 3-4 Star*	33.4%	39.3%	47%	49.6%

** These providers are eligible for CCAP higher rates for quality. Data representative of services provided in July of each year.*

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 childcare 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)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	73,445	39,156	0		18,015	84,575	38,725	142,618
3000 - Federal	73,465	74,889	100,395	118,845	137,217	193,130	137,217	200,954
Total	**146,910**	**114,045**	**100,395**	**118,845**	**155,232**	**277,705**	**175,942**	**343,572**
Biennial Change				(41,715)		213,697		300,274
Biennial % Change				(16)		97		137
Governor's Change from Base								86,577
Governor's % Change from Base								20
Expenditures by Category								
Operating Expenses		5,004						
Grants, Aids and Subsidies	146,910	109,041	100,395	118,845	155,232	277,705	175,942	343,572
Total	**146,910**	**114,045**	**100,395**	**118,845**	**155,232**	**277,705**	**175,942**	**343,572**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		3,955						
Direct Appropriation	77,400	39,156		0	18,015	84,575	38,725	142,618
Cancellations	3,955	3,955						
Expenditures	**73,445**	**39,156**	**0**		**18,015**	**84,575**	**38,725**	**142,618**
Biennial Change in Expenditures				(112,601)		102,590		181,343
Biennial % Change in Expenditures				(100)				
Governor's Change from Base								78,753
Governor's % Change from Base								77
3000 - Federal								
Balance Forward In	34,430	20,650	8,526	2,803	2,803	2,803	2,803	2,803
Receipts	59,685	62,764	94,672	118,845	137,217	193,130	137,217	200,954
Balance Forward Out	20,650	8,526	2,803	2,803	2,803	2,803	2,803	2,803
Expenditures	**73,465**	**74,889**	**100,395**	**118,845**	**137,217**	**193,130**	**137,217**	**200,954**
Biennial Change in Expenditures				70,886		111,107		118,931
Biennial % Change in Expenditures				48		51		54
Governor's Change from Base								7,824
Governor's % Change from Base								2

Program: Forecasted Programs
Activity: General Assistance

https://mn.gov/dhs/people-we-serve/people-with-disabilities/economic-assistance/income/programs-and-services/

AT A GLANCE

- In FY21, the General Assistance (GA) program supported a monthly average of 25,501 people.
- The typical monthly benefit is $203 for an individual and $260 for a couple.
- All funds spending for General Assistance activity for FY 21 was $56.1 million, which represented 0.27% of the overall agency budget.

PURPOSE AND 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. GA helps people meet some of their basic and emergency needs, commonly while they are homeless, transitioning out of homelessness, or receiving treatment.

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. For most recipients, GA is a transitory, short-term benefit.

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.

The maximum monthly benefit is $203 for a single adult (about 19 percent of the Federal Poverty Guideline of $1,063 per month for one person), $260 for a couple, and $104 for a person living in a residential facility or receiving Housing Support benefits.

In December 2019, nearly 40 percent of GA recipients received the lower benefit amount as a personal needs allowance while residing in residential facilities, such as mental health or substance use disorder treatment, and nursing facilities, or while receiving Housing Support.

The Emergency General Assistance (EGA) program provides additional emergency funds, no more than once in a twelve-month period, if a recipient cannot pay for basic needs and the person's health or safety is at risk.

Counties and tribes administer the General Assistance program on behalf of the Department of Human Services.

RESULTS

GA is a safety net program that helps people stabilize crisis situations, avoid homelessness and connect to other resources. It is intended to be short-term while recipients apply for other longer-term, stable benefits, or return to employment. It is not intended as a long-term solution to meet a person's basic needs. As mentioned above, a substantial number of GA recipients are living in a facility, including a mental health or substance use disorder treatment facility, or receiving Housing Support benefits, while receiving GA benefits. The table below shows that a substantial percent of GA recipients also receives benefits while experiencing homelessness.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Percent of GA recipients that are homeless	25.1%	25.2%	Dec. 2018 Dec. 2019
Quantity	Percent of GA recipients receiving Housing Support benefits	26.8%	27.9%	Dec. 2018 Dec. 2019
Quantity	Percent of GA recipients living in a mental health facility	7.7%	7.6%	Dec. 2018 Dec. 2019
Quantity	Percent of GA recipients living in a substance use disorder treatment facility	2.7%	2.6%	Dec. 2018 Dec. 2019

The source for these outcomes is the December 2019 General Assistance Report: Households and enrollees, published in August 2021 (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6128L-ENG). This was the most recent information available.

The legal authority for the General Assistance program is M.S. chapter 256D (https://www.revisor.mn.gov/statutes/?id=256D)

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	49,778	54,049	49,691	49,665	51,966	53,034	52,018	74,725
2000 - Restrict Misc Special Revenue		1,962		150	150	150	150	150
Total	**49,778**	**56,011**	**49,691**	**49,815**	**52,116**	**53,184**	**52,168**	**74,875**
Biennial Change				(6,283)		5,794		27,537
Biennial % Change				(6)		6		28
Governor's Change from Base								21,743
Governor's % Change from Base								21
Expenditures by Category								
Operating Expenses				49,665	51,966	53,034	51,966	53,034
Grants, Aids and Subsidies	49,778	56,011	49,691	150	150	150	202	21,841
Total	**49,778**	**56,011**	**49,691**	**49,815**	**52,116**	**53,184**	**52,168**	**74,875**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		1,293						
Direct Appropriation	51,071	55,652	49,399	49,665	51,966	53,034	52,018	74,725
Transfers In	6,730	6,730	7,022	6,730	6,730	6,730	6,730	6,730
Transfers Out	6,730	6,730	6,730	6,730	6,730	6,730	6,730	6,730
Cancellations	1,293	2,896						
Expenditures	**49,778**	**54,049**	**49,691**	**49,665**	**51,966**	**53,034**	**52,018**	**74,725**
Biennial Change in Expenditures				(4,471)		5,644		27,387
Biennial % Change in Expenditures				(4)		6		28
Governor's Change from Base								21,743
Governor's % Change from Base								21
2000 - Restrict Misc Special Revenue								
Balance Forward In	2	45						
Receipts	44	1,917		150	150	150	150	150
Balance Forward Out	45							
Expenditures		**1,962**		**150**	**150**	**150**	**150**	**150**
Biennial Change in Expenditures				(1,812)		150		150
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								0

https://mn.gov/dhs/people-we-serve/people-with-disabilities/economic-assistance/income/programs-and-services/

AT A GLANCE

- In FY21, the Minnesota Supplemental Aid program supported a monthly average of 32,467 people.
- The typical benefit is $81 for an individual and $111 for a couple.
- All funds spending for Minnesota Supplemental Aid activity for FY21 was $50.075 million, which represented 0.25% of the overall agency budget.

PURPOSE AND CONTEXT

Minnesota Supplemental Aid (MSA) is a state-funded program that supports adults who receive, or are eligible for, federal Supplemental Security Income (SSI) benefits. MSA benefits help cover basic personal, home, and transportation needs. The program offers monthly cash benefits for people who have low income and few resources and are age 65 or older, blind or disabled. This program is a critical component in helping Minnesotans with disabilities or older adults achieve longer-term housing and economic stability.

SERVICES PROVIDED

MSA provides a state-funded monthly cash supplement to help people who are older adults, blind or have a disability, and who receive SSI benefits. As of FY21, the average grant amount is $128.53. In addition, some MSA recipients also receive a special needs increase to their grant, usually to accommodate medically necessary special diets. MSA also supports recipients by partially offsetting the expenses of having a representative payee, guardian, or conservator.

Recipients can receive MSA benefits while living in their own home, or a reduced amount if they are residing in a nursing or intermediate care facility. In FY21, about 2 percent of enrollees lived in a Medical Assistance certified facility.

In addition, MSA housing assistance is available to qualified recipients, adding $392 in FY21 to the MSA benefit to help pay high 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, and
- Meet one of the following criteria: (1) relocating from an institution, (2) eligible for Medical Assistance personal care attendant services, (3) receiving waivered services and living in their own place, or (4) transitioning from a Housing Support setting.

A person who receives federal or state rental assistance or lives in subsidized housing is not eligible for MSA Housing Assistance.

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

In FY21, the MSA program had an average monthly enrollment of 32,467. MSA benefits help low-income individuals with disabilities, or who are older, live successfully in the community and maintain longer-term economic stability. As shown in the table below, many people stay on MSA benefits for extended periods of time.

Name of Measure	*Number of Months*	*Number of Years*
Average cumulative amount of time a person receives MSA benefits	107 months	9 years

Many MSA recipients also receive an increase to their grant amount to ensure that they are able to meet the requirements of a medically-prescribed diet. The table below shows the number and percentage of recipients who benefit from this program.

Name of Measure	*Number*	*Percent*
Number and percent of MSA recipients who receive additional funds for medically necessary dietary needs	6,681	21.0%

MSA 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. This is consistent with the One Minnesota goal of providing access to affordable housing and to enabling people with disabilities to live in community-based settings.

Name of Measure	*Number*	*Percent*
Number and percent of MSA recipients who receive MSA housing assistance	1,384 households/cases	4.4%

All of these tools help advance the goal of meeting people's needs and promote stability.

The source for these outcomes are from data used for the DHS report, December 2019 Minnesota Supplemental Aid: Households and enrollees. December 2019 Minnesota Supplemental Aid (mn.gov). This was the most recent information available.

In addition, information was included from DHS reports and forecasts information: background_forecast_tables_0222_tcm1053-520081.xlsx (live.com)

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.

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	43,503	50,075	50,060	54,882	58,302	59,845	58,548	60,357
2000 - Restrict Misc Special Revenue	3	0		5	5	5	5	5
Total	**43,506**	**50,076**	**50,060**	**54,887**	**58,307**	**59,850**	**58,553**	**60,362**
Biennial Change				11,366		13,210		13,968
Biennial % Change				12		13		13
Governor's Change from Base								758
Governor's % Change from Base								1
Expenditures by Category								
Grants, Aids and Subsidies	43,506	50,076	50,060	54,887	58,307	59,850	58,553	60,362
Total	**43,506**	**50,076**	**50,060**	**54,887**	**58,307**	**59,850**	**58,553**	**60,362**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		18						
Direct Appropriation	43,521	51,646	52,097	54,882	58,302	59,845	58,548	60,357
Transfers Out			292					
Cancellations	18	1,589	1,745					
Expenditures	**43,503**	**50,075**	**50,060**	**54,882**	**58,302**	**59,845**	**58,548**	**60,357**
Biennial Change in Expenditures				11,364		13,205		13,963
Biennial % Change in Expenditures				12		13		13
Governor's Change from Base								758
Governor's % Change from Base								1
2000 - Restrict Misc Special Revenue								
Receipts	3	0		5	5	5	5	5
Expenditures	**3**	**0**		**5**	**5**	**5**	**5**	**5**
Biennial Change in Expenditures				2		5		5
Biennial % Change in Expenditures				58				
Governor's Change from Base								0
Governor's % Change from Base								0

Program: Forecasted Programs
Activity: Housing Support

https://mn.gov/dhs/people-we-serve/seniors/economic-assistance/housing/programs-and-services/housing-support.jsp

AT A GLANCE

- In FY22, the Housing Support program served a monthly average of 21,319 people.
- The current room and board rate limit is $1,041 for group settings, and $1,091 for community settings.
- The average monthly payment per recipient in FY22 was $745.
- All funds spent for the Housing Support activity for FY22 was $175 million, which represented 0.86% of the overall agency budget.

PURPOSE AND CONTEXT

Housing Support is a state-funded income support that pays for housing related costs for adults with disabilities, or who are age 65 or older, and who have low income and live in authorized settings. Payments are made directly to a housing provider authorized by a county or tribe. Recipients may receive Housing Support in a licensed facility, or an authorized community-based setting, such as their own home. The program aims to reduce and prevent institutional residence or homelessness.

SERVICES PROVIDED

The Housing Support room and board rate is currently $1,041 per month in group settings. Starting in July 2022, the rate for community settings (people living in supportive housing settings with their own lease) is $1,091 per month. This amount is used to pay for rent, utilities, food, household supplies and other items needed to provide room and board to a recipient. Recipients are required to pay a portion of their income directly to providers toward the room and board rate. Housing Support can pay for additional supportive services in some settings if a recipient is not eligible for home-and community- based waiver services or personal care assistance.

Individuals can receive Housing Support benefits in a wide range of eligible settings, with the most common being adult foster care, assisted living, board and lodges, and scattered-site and site-based supportive housing. These numbers are shown in Table 1.

Table 1: Housing Support Setting Type and Number of People Served as of 12/31/2019 and 6/1/2022

Setting Type	Total # of People as of Dec 31, 2019	Total # of People as of June 1, 2022
Adult Foster Care	8,805	8,121
Assisted Living	3,187	3,028
Board and Lodges	4,574	4,218
Boarding Care Homes	372	307
Homeless Supportive Housing	3,723	4,734
Total	**20,661**	**20,168**

Counties and tribes manage Housing Support agreements with providers. County human services agencies process eligibility and payments for people in the program.

RESULTS

While Housing Support recipients are eligible to live in a wide range of settings, an increasing percentage of recipients live in community settings with a lease. This trend, shown in the chart below, aligns with a vision statement for housing from Minnesota's 2020 Olmstead Plan:

"People with disabilities will choose where they live, with whom, and in what type of housing. They can choose to have a lease or own their own home and live in the most integrated setting appropriate to their needs. Supports and services will allow sufficient flexibility to support individuals' choices on where they live and how they engage in their communities."

The Housing Support program is used to support people with disabilities to move out of institutional settings and into more integrated settings.

Type of Measure	***Name of Measure***	***CY2020***	***CY2021***
Quantity	Number of moves out of institutions into settings using Housing Support	933	942

The percent of Housing Support recipients living in the community has grown over the past three years.

Type of Measure	***Name of Measure***	***Dec. 2019***	***Dec. 2020***	***Dec. 2021***
Quantity	Percent of recipients living in community settings with a lease	21%	21.5%	22.5%

Housing Support resources support people to move out of homelessness.

Type of Measure	***Name of Measure***	***CY2020***	***CY2021***
Quantity	Number of moves out of homelessness into settings using Housing Support (does not include shelter or crisis stays)	4,158	4,379

Homelessness disproportionately impacts people of color and American Indians in Minnesota. Data below shows how Housing Support is used to address those disparities with permanent housing solutions. Data sources include: American Community Survey, DHS MAXIS eligibility system.

Type of Measure	***Name of Measure***	***General population in Minnesota***	***Adults homeless on public assistance Dec. 2020***	***Permanent Supportive Housing Dec. 2021***
Quantity	Percent of adults who are Black	6.8%	35.2%	36.3%
Quantity	Percent of adults who are American Indian	1.1%	15.8%	12.4%

The legal authority for the Housing Support program is M.S. chapter 256I (https://www.revisor.mn.gov/statutes/?id=256I).

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	181,977	180,926	177,530	201,877	211,138	218,858	211,692	224,225
2000 - Restrict Misc Special Revenue	2,655	18	2,544	2,475	2,475	2,475	2,475	2,475
3010 - Coronavirus Relief		19						
Total	**184,631**	**180,963**	**180,074**	**204,352**	**213,613**	**221,333**	**214,167**	**226,700**
Biennial Change				18,832		50,520		56,441
Biennial % Change				5		13		15
Governor's Change from Base								5,921
Governor's % Change from Base								1
Expenditures by Category								
Operating Expenses	4,995			363	7,938	7,938	7,938	7,938
Grants, Aids and Subsidies	179,637	180,963	180,074	203,989	205,675	213,395	206,229	218,762
Total	**184,631**	**180,963**	**180,074**	**204,352**	**213,613**	**221,333**	**214,167**	**226,700**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		4,828						
Direct Appropriation	180,495	181,213	181,364	201,877	211,138	218,858	211,692	224,225
Transfers In	6,200							
Cancellations	4,718	5,114	3,834					
Expenditures	**181,977**	**180,926**	**177,530**	**201,877**	**211,138**	**218,858**	**211,692**	**224,225**
Biennial Change in Expenditures				16,504		50,589		56,510
Biennial % Change in Expenditures				5		13		15
Governor's Change from Base								5,921
Governor's % Change from Base								1
2000 - Restrict Misc Special Revenue								
Balance Forward In		228	2,645	2,135	2,135	2,135	2,135	2,135
Receipts	2,672	2,245	2,034	2,475	2,475	2,475	2,475	2,475
Balance Forward Out	17	2,455	2,135	2,135	2,135	2,135	2,135	2,135
Expenditures	**2,655**	**18**	**2,544**	**2,475**	**2,475**	**2,475**	**2,475**	**2,475**
Biennial Change in Expenditures				2,347		(69)		(69)
Biennial % Change in Expenditures				88		(1)		(1)
Governor's Change from Base								0
Governor's % Change from Base								0
3010 - Coronavirus Relief								
Direct Appropriation		1,135						
Cancellations		1,116						
Expenditures		**19**						
Biennial Change in Expenditures				(19)		0		0
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								

Program: Forecasted Programs
Activity: Northstar Care for Children

https://mn.gov/dhs/people-we-serve/children-and-families/services/foster-care/
https://mn.gov/dhs/people-we-serve/children-and-families/services/adoption/

AT A GLANCE

- 12,312 children experienced an out-of-home placement in 2021.
- 1,719 children were either adopted or had a permanent transfer of legal custody to a relative in 2021.
- All fund spending for the North Star Care for Children activity for FY 2021 was $158 million. This represented 0.8 percent of the Department of Human Services overall budget.

PURPOSE AND CONTEXT

Northstar Care for Children is designed to help children who are removed from their homes. It 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 averages about $12,000 annually per child. Northstar Care for Children consolidates and simplifies administration of three existing programs: Family Foster Care, Kinship Assistance (which replaced Relative Custody Assistance), and Adoption Assistance. Northstar Care for Children will help more children grow up in safe and permanent homes.

SERVICES PROVIDED

The 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. It is not used for group housing or residential treatment.
    - Northstar Kinship Assistance replaced the previous Relative Custody Assistance program, simplifying ongoing requirements for caregivers and using federal Title IV-E foster care funds.
    - Northstar Adoption Assistance allows more decision making by adoptive parents, rather than requiring detailed state review and approval.
- Provides a monthly basic benefit based on children's age.
- Uses a uniform assessment for all children to determine needs beyond the basic payment. The assessment results in 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 unless they specifically transition into Northstar Care for Children (The current programs are phased out as children exit them).
- Reduces barriers to permanency by eliminating disparities in benefits across existing programs.
- Reduces racial disparities among 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 and tribal spending on foster care. Northstar Care for Children spending is eligible for the temporary 6.2 percent Federal Medical Assistance Percentage (FMAP) increase authorized by the Families First Coronavirus Response Act (FFCRA).[1]

RESULTS

The Minnesota Department of Human Services monitors the performance of counties and tribes in delivering child welfare services, including services provided under Northstar Care for Children.

Type of Measure	*Name of Measure*	*2019*	*2021*
Quality	**Rate of Relative Care:** Of all days that children spent in family foster care settings during the given period, what percentage of days were spent with a relative?	60.9%	62.5%
Quality	**Placement Stability:** Of all children who enter foster care in the year, what is the number of placement moves per 1,000 days spent in foster care?	3.9 per 1,000	3.4 per 1,000
Quality	**Permanency, 12-23 months**: Of all children in foster care who had been in foster care between 12 and 23 months on the first day of the year, what percent discharged from foster care to permanency within 12 months of the first day of the year?	55.5%	54.3%
Quality	**Permanency, 24 months**: Of all children in foster care who had been in foster care for 24 months or more on the first day of the year, what percent discharged to permanency within 12 months of the first day of the year?	33.4%	37.7%

Performance Measures notes:
Measures provided by the Child Safety and Permanency Division at the Department of Human Services.

Also see the DHS 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).

[1] The Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127). Section 6008 of the FFCRA provides a temporary 6.2 percentage point increase to each qualifying state's Federal Medical Assistance Percentage (FMAP) beginning January 1, 2020, and through the last day of the calendar quarter in which the COVID-19 public health emergency declared by the Secretary of Health and Human Services terminates.

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	91,064	87,140	93,682	98,343	113,912	125,606	113,912	124,546
3000 - Federal	60,072	71,641	69,157	61,986	87,834	103,303	87,834	102,805
Total	**151,136**	**158,781**	**162,839**	**160,329**	**201,746**	**228,909**	**201,746**	**227,351**
Biennial Change				13,251		107,487		105,929
Biennial % Change				4		33		33
Governor's Change from Base								(1,558)
Governor's % Change from Base								(0)
Expenditures by Category								
Operating Expenses	2	1						
Grants, Aids and Subsidies	151,134	158,780	162,839	160,329	201,746	228,909	201,746	227,351
Total	**151,136**	**158,781**	**162,839**	**160,329**	**201,746**	**228,909**	**201,746**	**227,351**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		3,759						
Direct Appropriation	94,647	95,625	100,970	98,343	113,912	125,606	113,912	124,546
Cancellations	3,583	12,244	7,288					
Expenditures	**91,064**	**87,140**	**93,682**	**98,343**	**113,912**	**125,606**	**113,912**	**124,546**
Biennial Change in Expenditures				13,821		47,493		46,433
Biennial % Change in Expenditures				8		25		24
Governor's Change from Base								(1,060)
Governor's % Change from Base								(0)
3000 - Federal								
Balance Forward In	8	633	11	1,874	1,874	1,874	1,874	1,874
Receipts	60,065	71,007	71,020	61,986	87,834	103,303	87,834	102,805
Balance Forward Out			1,873	1,874	1,874	1,874	1,874	1,874
Expenditures	**60,072**	**71,641**	**69,157**	**61,986**	**87,834**	**103,303**	**87,834**	**102,805**
Biennial Change in Expenditures				(570)		59,994		59,496
Biennial % Change in Expenditures				(0)		46		45
Governor's Change from Base								(498)
Governor's % Change from Base								(0)

Program: Forecasted Programs
Activity: MinnesotaCare

https://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/minnesotacare.jsp

AT A GLANCE

- In FY 2021, MinnesotaCare had an average monthly enrollment of 93,000.
- Total MinnesotaCare program expenditures reached $635 million in FY 2021. This represented 3.1 percent of the Department of Human Services overall budget.
- The Minnesota state share of total MinnesotaCare program expenditures in FY2021 was $33 million.

PURPOSE AND CONTEXT

The MinnesotaCare Program was established in 1992 to provide affordable health coverage for people with incomes too high for Medicaid but unable to afford other health insurance. It provided a subsidized program for children and parents and later expanded to include adults. In 2017, MinnesotaCare coverage was expanded to include Deferred Action for Childhood Arrivals (DACA) grantees who meet program eligibility requirements.

Passage of the Affordable Care Act (ACA) in 2010, and subsequent state legislation, made many MinnesotaCare enrollees eligible for Medical Assistance (MA). Under the authority of the ACA, Minnesota established MinnesotaCare as a Basic Health Plan to provide health coverage for people with incomes between 138 percent and 200 percent of federal poverty guidelines. As a Basic Health Program (BHP), Minnesota receives federal funds equal to 95 percent of the advanced premium tax credits that would otherwise be available to eligible people enrolled in commercial health care coverage through MNsure rather than in MA where federal funding is tied to expenditures. In fiscal year 2021, federal Basic Health Plan funding covered 74 percent of MinnesotaCare's costs. The amount of federal funding varies year to year based on individual market premiums, enrollment, the geographic distribution of enrollees, and federal regulatory action. Federal BHP revenues are deposited into the BHP Trust Fund and used to fund eligible expenditures in the MinnesotaCare program. Historically, the BHP Trust Fund has had a surplus which has resulted in reductions to state expenditures.

Today, MinnesotaCare provides comprehensive health care coverage for about 93,000 Minnesotans who pay no more than $80 per month in premiums; due to federal law changes. The program also includes additional benefits not necessarily available or as affordable on MNsure, including dental, vision, and a broad array of behavioral health benefits.

During the coronavirus (COVID-19) pandemic, MinnesotaCare coverage has been maintained for all individuals enrolled on and after March 18, 2020, through the end of the month in which the federal public health emergency ends, unless the individual requests a voluntary closure of their coverage, ceases to be a resident of the state, or has died. This was done in order to align it with coverage requirements in Medical Assistance required under the Families First Coronavirus Response Act (FFCRA). Coverage for these enrollees has continued regardless of whether or not the enrollee has paid their monthly premium. As of August 2022, the Public Health Emergency declaration has not yet ended.

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 website 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; however changes made in the federal American Rescue Plan Act (ARPA) of 2021 reduced the highest premium to $28 through Calendar Year 2022. This change was further extended through Calendar Year 2025 by the Inflation Reduction Act of 2022.

RESULTS

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Result	Percent of Minnesotans without health insurance[1]	4.7%	4.0%	2019 to 2021
Result	Percent of Low Income Minnesotans without Health Insurance[2]	8.9%	8.5%	2019 to 2021
Quantity	Total number of MHCP enrollees served by an IHP[3] Number of MinnesotaCare enrollees served by an IHP	428,664 20,764	470,576 32,872	2020 to 2021
Quality	Estimated reduction in health care expenditures (below projections) for providers in Integrated Health Partnership demonstration project[4]	$7.56 million	$27.56 million	2019 to 2021

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 2019 (Previous) and 2021 (Current)
2. Measure is the percentage of uninsured Minnesotans with family income below 200 percent of poverty. Source: Minnesota Health Access Survey, Minnesota Department of Health. Compares 2019 (Previous) and 2021 (Current)
3. Measure is the number of enrollees served by an IHP provider. Compares 2020 (Previous) and 2021 (Current).
4. Measure is an estimated reduction in annual medical costs below projections for 2019 and 2021 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. This number includes savings to providers, health plans, the federal government, and the state. Integrated Health Partnerships (IHPs) allow participating providers to enter into an arrangement with DHS to care for enrollees under a payment model that holds the participants accountable for the costs and quality of care their Medicaid patients receive. The goal of the program is to improve the quality and value of care provided to Medicaid and MinnesotaCare enrollees while lowering the cost through innovative approaches to care and payment.

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.

[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.

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
2360 - Health Care Access	57,016	65,817	61,226	50,201	90,336	52,037	99,551	60,957
3000 - Federal	395,615	470,216	575,389	614,223	550,129	557,603	550,129	557,603
Total	**452,631**	**536,034**	**636,615**	**664,424**	**640,465**	**609,640**	**649,680**	**618,560**
Biennial Change				312,374		(50,934)		(32,799)
Biennial % Change				32		(4)		(3)
Governor's Change from Base								18,135
Governor's % Change from Base								1
Expenditures by Category								
Operating Expenses				1				
Grants, Aids and Subsidies	452,631	536,034	636,615	664,423	640,465	609,640	649,680	618,560
Total	**452,631**	**536,034**	**636,615**	**664,424**	**640,465**	**609,640**	**649,680**	**618,560**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
2000 - Restrict Misc Special Revenue								
Balance Forward In	12	23	6					
Receipts	(2)	(23)	(6)					
Balance Forward Out	10		0					
2360 - Health Care Access								
Balance Forward In	124	1,091	72	1				
Direct Appropriation	27,097	33,775	69,859	44,315	85,007	47,148	94,222	56,068
Receipts	30,816	33,049	6,152	5,885	5,329	4,889	5,329	4,889
Transfers In	163	175	73,711		37,990		37,990	
Transfers Out	163	175	73,711		37,990		37,990	
Cancellations	1,011	2,098	14,856					
Balance Forward Out	9		1					
Expenditures	**57,016**	**65,817**	**61,226**	**50,201**	**90,336**	**52,037**	**99,551**	**60,957**
Biennial Change in Expenditures				(11,407)		30,946		49,081
Biennial % Change in Expenditures				(9)		28		44
Governor's Change from Base								18,135
Governor's % Change from Base								13
3000 - Federal								
Balance Forward In	411,956	271,357	135,914	184,550	184,550	184,550	184,550	184,550
Receipts	254,899	334,612	624,025	614,223	550,129	557,603	550,129	557,603
Balance Forward Out	271,240	135,753	184,550	184,550	184,550	184,550	184,550	184,550
Expenditures	**395,615**	**470,216**	**575,389**	**614,223**	**550,129**	**557,603**	**550,129**	**557,603**
Biennial Change in Expenditures				323,781		(81,880)		(81,880)
Biennial % Change in Expenditures				37		(7)		(7)
Governor's Change from Base								0
Governor's % Change from Base								0

https://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp

AT A GLANCE

- In FY19, Medical Assistance (MA) served a monthly average of 1,200,000 people. This is 20.7 percent of the state's population.
- In FY21, MA provided coverage for:
  - 26,043 births (about 4 in 10 of all live births in Minnesota)
  - 248,905 people receiving mental health services
  - 409,717 people receiving dental services
- In FY21, the families with children group made up 65 percent of total MA enrollment, but only 23.8 percent of total program expenditures.
- In FY21, coverage for older adults and people with disabilities made up 15 percent of total enrollment, but 62 percent of total program expenditures.
- MA is funded with state general funds, the health care access fund, federal Medicaid funds, and local shares for a several services.
- All funds spending for the Medical Assistance activity for FY21was $13.7 billion. This represented 67.4 percent of the Department of Human Services overall budget.
- The Minnesota state share of total MA expenditures in FY21 was approximately $5.4 billion.

PURPOSE AND CONTEXT

Medical Assistance (MA) is Minnesota's Medicaid program. MA is Minnesota's largest public health care program and serves children and families, pregnant women, adults without children, older adults and people who are blind or have a disability. It covers one out of every five Minnesotans. As the third largest insurer in the state after self-insured employer-based coverage and Medicare, it makes up nearly 22 percent of the state's health insurance market.[1]

MA provides basic health care, home-and community-based services and long-term care services. Most people who have MA get health care through health plans. You can choose a health plan from those serving MA members in your county. Members who do not get health care through a health plan get care on a fee-for-service basis, with providers billing the state directly for services they provide.

On July 30, 1965, President Lyndon B. Johnson signed into law legislation that led to the establishment of Medicare and Medicaid. Medicaid serves almost 25 percent of the nation's population. Medicaid contributes significantly to the financing of the U.S. health care system, supporting local public health infrastructure, hospitals, mental health centers, at-home care, community clinics, nursing homes, physicians and many other health professions. Medicaid — not Medicare — is the primary source of coverage for people who need long-term care services, such as nursing home services. In 1966, Minnesota implemented Medical Assistance (MA).

[1] "Medicaid Matters: The Impact of Minnesota's Medicaid Program." Available at https://www.leg.state.mn.us/docs/2018/other/180391.pdf.

Currently, the federal government shares financial responsibility for the Medicaid program by matching state costs with federal dollars. While certain federal requirements outline who and what must be covered in each program, states generally have flexibility to tailor and expand their Medicaid program to meet the needs of their population and state budgets.

The Minnesota Department of Human Services (DHS) is the state Medicaid agency and partners with all 87 Minnesota counties and several Minnesota Indian Tribes to administer MA. DHS contracts with both health plans and health care providers across the state to deliver basic health care to MA enrollees.

Minnesotans may enroll in MA if they meet certain eligibility requirements under the following categories: (a) parents and children; (b) age 65 or older, blind or have disabilities; and (c) adults without dependent children.

An individual's eligibility is determined by factors such as household income, family size, age, disability status, and citizenship or immigration status. These criteria are set by federal and state law and vary by category. Enrollees must demonstrate their program eligibility at least once a year. All individuals who meet federal eligibility requirements are guaranteed coverage. States can expand upon the minimum federal requirements, add optional or special populations to their programs or increase the income eligibility limits. Individuals eligible for Medicaid are guaranteed a basic set of benefits covering specific services and settings.

Minnesota is known for its comprehensive approach to providing Medicaid coverage. Minnesota covers a broad group of people and services beyond the minimum standards set in federal law. This includes expanding coverage to higher-income children and adults and covering long-term services and supports in the home and community instead of an institutional setting. Minnesota also covers many special populations in need of services who would otherwise be ineligible for Medicaid because of their income level, including children with disabilities whose parents are given the option to access Medicaid by paying a parental fee, women who have been diagnosed with breast or cervical cancer through the state's cancer screening program, and families in need of family planning services.

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 services and supports for people with disabilities and older adults so that they can continue living in the community.

Home and community-based services (HCBS) waivers were established under section 1915(c) 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-1980s. The expansions have focused on low-income, uninsured, or under-insured children as well as eligibility changes to better support older adults 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 as efforts to develop home and community-based alternatives gained momentum.

The most significant recent changes to the Minnesota MA program followed legislative action during the 2013 session and applied to people without an aged, blind, or disabled basis of eligibility. These changes included an elimination of asset 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. This resulted in over 110,000 former MinnesotaCare recipients transitioning to coverage under MA in January of 2014.

During the coronavirus (COVID-19) pandemic, DHS has preserved access to health care programs in accordance with Emergency Executive Orders 20-11[2] and 20-12[3], and to qualify for a temporary 6.2 percent Federal Medical Assistance Percentage (FMAP) increase authorized by the Families First Coronavirus Response Act (FFCRA).[4] To qualify for the FMAP increase, the state must maintain Medicaid (MA in Minnesota) for all individuals enrolled on and after March 18, 2020, through the end of the month in which the federal public health emergency ends, unless the individual requests a voluntary closure of their coverage, ceases to be a resident of the state or has died. As of August 2022, continuous coverage requirements remain in place until the end of the federal Public Health Emergency, whose end has not yet been announced.

During the COVID-19 pandemic, the 2020 Minnesota legislature also passed a law authorizing a new Medicaid coverage group for COVID-19 testing of the uninsured. The new coverage group was effective May 1, 2020, and ends when the federal COVID-19 public health emergency ends.

In addition, DHS's pandemic response included expedited reimbursement to nursing facilities and customized living settings (in accordance with Minn. Stat. sec. 12A.10 - https://www.revisor.mn.gov/statutes/cite/12A.10) to support aggressive efforts to limit COVID-19 exposure and to prevent the spread of COVID-19 within facilities.

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 Long-Term Services and Supports (LTSS)
Thirty years ago, people who needed help with daily living tasks, such as bathing, dressing, eating and preparing meals, and going to the bathroom, were faced with the choice of when, not if, they would move from their home into an institution or similar setting. Today, older Minnesotans and people with disabilities have many options and services available. This approach provides a higher quality of life for people as they have access to the right service at the right time, and it leads to more cost-effective services over time.

LTSS are a spectrum of health and social services that support Minnesotans who need help with daily living tasks. The services generally consist of ongoing care or supports that a person needs to manage a chronic health condition or disability. The services can be provided in institutional settings, such as hospitals and nursing homes, or in people's homes and other community settings. Federal law requires all state Medicaid programs to cover these services when provided in an institutional setting or nursing facility.

[2] Emergency Executive Order 20-11. https://mn.gov/governor/assets/FINAL_EO-20-11%20Continue%20Human%20Services_tcm1055-424359.pdf .
[3] Emergency Executive Order 20-12. https://mn.gov/governor/assets/4a.%20Emergency%20Executive%20Order%2020-12_FINALFiled%202_tcm1055-425482.pdf
[4] The Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127). Section 6008 of the FFCRA provides a temporary 6.2 percentage point increase to each qualifying state's Federal Medical Assistance Percentage (FMAP) beginning January 1, 2020, and through the last day of the calendar quarter in which the COVID-19 public health emergency declared by the Secretary of Health and Human Services terminates.

MA Coverage of Long-Term Care Facilities

A nursing home provides 24-hour care and supervision in a residential facility setting. Nursing homes 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. Alternatively, an intermediate care facility for persons with developmental disabilities (ICF/DD) provides 24-hour care, active treatment, training and supervision to people with developmental disabilities. Additionally, day training and habilitation (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.

MA pays for long-term care services for people who reside in facilities. In FY 2019, over 13,100 people per month received facility based long term care services. Total spending on this group was about $1.1 billion FY 2021, about $460 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.

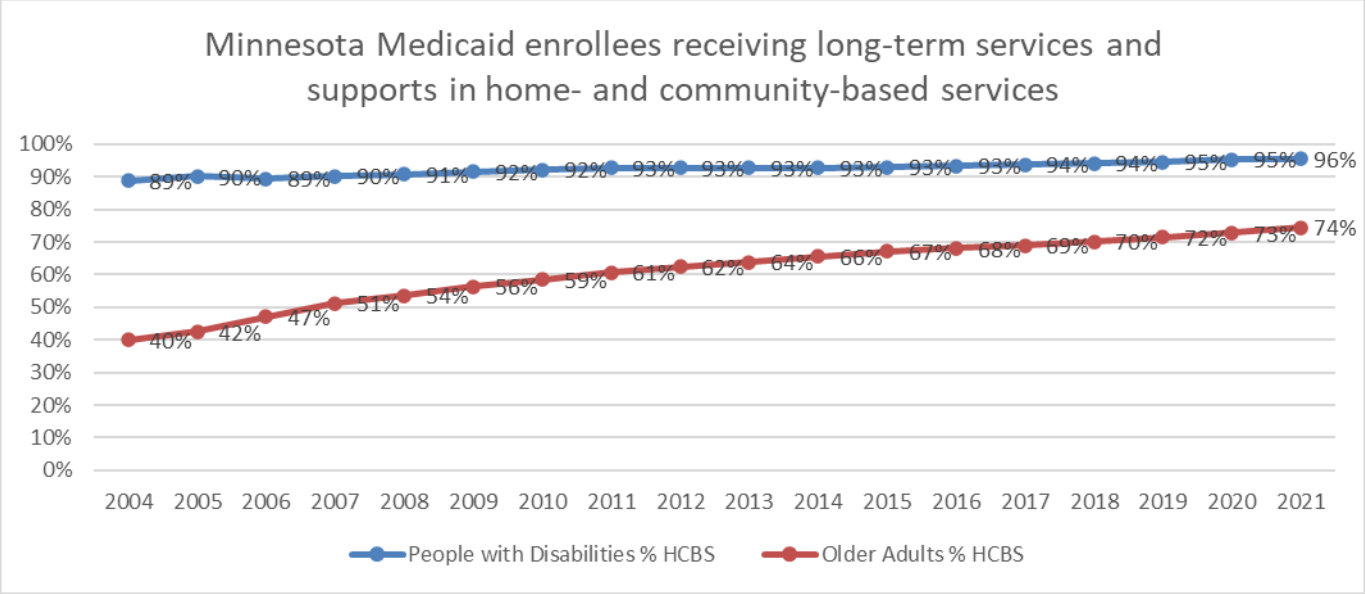
To receive MA long-term care services, a person must have income and assets that are below allowable limits and have an assessed need for the services. DHS works with community providers, counties and tribes, and the Department of Health in administering and monitoring services in these long-term care settings. More information is available at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5961-ENG.

MA Coverage of Care Through Home and Community-Based Services

Home and community-based services are long-term services and supports delivered in homes or communities and not institutional settings. Congress established home and community-based services waivers in 1983 in section 1915(c) of the Social Security Act, giving states the option to seek a waiver of Medicaid rules governing institutional care to allow them to expand Medicaid services to home and community settings.

Minnesota has a long history of working to help all people live with dignity and independence. For more than 35 years, Minnesota has expanded long-term services and supports coverage to individuals receiving services in their homes and communities, which is often more effective and desirable than an institutional setting. In order to ensure that people with disabilities and older adults enjoy the same quality of life as other Minnesotans, the services and supports that they depend on must be available in the homes and communities where they choose to live.

By 1995, Minnesota had shifted from predominantly institution-based care to predominantly home- and community-based care. Home and community-based services are generally more cost effective and preferred by the people who rely on services. The chart below shows that more enrollees receiving LTSS choose home and community-based services in Minnesota each year.



Minnesota began offering some home and community based care as a Medicaid state plan option in 2005. The state also receives federal approval to use Medicaid dollars to pay for other home and community based services through its home and community-based services waiver programs. These programs allow Medicaid to pay for services for people in their homes and communities if the services would otherwise be eligible for coverage in nursing facilities or hospitals.

DHS administers waiver programs in collaboration with county and tribal social services and public health programs. The vast majority of Minnesota's Medicaid spending on long-term care services and supports goes to enrollees in home- and community-based waiver programs. For example, around 92 percent of Medicaid long-term care spending for people with disabilities in Minnesota goes toward services provided in the community.

In FY 2021, an average of nearly 77,000 people received home care and waivered services per month. Total spending on waiver and home care services was just over $4.5 billion in FY2021, and roughly half of this was from state funds.

Minnesota operates five home and community-based waivers:

- **Brain Injury (BI):** Allows Medicaid to cover services for people with a brain injury who need the level of care provided in a nursing facility or neurobehavioral hospital and choose to receive such care in home and community-based service settings.
- **Community Alternative Care (CAC):** Allows Medicaid to cover services for people who are in need of the level of care provided at a hospital and choose to receive such care in home or community-based service settings.
- **Community Access for Disability Inclusion (CADI):** Allows Medicaid to cover services for people who need the level of care provided in nursing facilities and choose to receive such care in home and community-based service settings.
- **Developmental Disabilities (DD):** Allows Medicaid to cover services for people with developmental disabilities who need the level of care provided at an intermediate care facility for people with developmental disabilities and choose to receive such care in home and community-based service settings.
- **Elderly Waiver (EW):** Allows Medicaid to cover services for those age 65 and older who need the level of care provided in a nursing facility and choose to receive such care in home and community-based service settings.

These waivers can offer:

- in-home and residential supports
- 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 and assistive technology
- case management
- other goods and services

Medical Assistance Basic Health Care

MA also provided comprehensive coverage outside of long-term care to over one million Minnesotans in FY 2019. Total spending for basic health care services reached about $8.4 billion in FY 2019, with $3 billion coming from state funds. The enhanced federal share available with the MA expansion in 2014 reduced the overall share of basic care expenditures to about 34.5 percent in FY 2021, a decrease from about 50 percent in FY 2013.

Basic health care services covered in the MA benefit 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 Older Adults and People with Disabilities

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 enables 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. Most MA-EPD enrollees are subject to paying a premium of at least $35 per month. Premiums are calculated on a sliding fee scale based on the enrollee's income and family size. 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).

In FY 2019, this segment of MA funds supported an average of 179,665 people per month, many of whom are also enrolled in Medicare and therefore are "dual eligible beneficiaries." Total spending on this group was over $2.9 billion in FY 2021, about 44 percent of which came from state funds.

MA Coverage of Basic Health Care for Families with Children
Enrollees in this eligibility category 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 (MA-BC). MFPP provides coverage of family planning and related health care services for people not currently enrolled in MA or MinnesotaCare. MA-BC covers treatment costs for breast cancer, cervical cancer, or a precancerous cervical condition for women without health insurance. In FY 2021, this segment of MA funds supported an average of 772,776 people per month. Total spending on this group was over$3.2 billion, about43 percent of which came from state funds.

MA Coverage of Basic Health Care for Adults without Children
In FY 2019, MA covered an average of almost 180,000 adults without dependent children people per month. Under the Affordable Care Act the federal government pays 90 percent of the expenditures for this population. Total spending on this group was about $2.2 billion, with about $215 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).

Today, Minnesota's Medicaid program is a cornerstone of our state's system of health and long-term care coverage, with almost 1.2 million people covered in 2021, including children, parents, people with disabilities and older adults.

RESULTS

Type of Measure	***Name of Measure***	***Previous***	***Current***	***Dates***
Quality	Percent of older adults served by home and community-based services[1]	72.8%	79.1%	FY2017 to FY2021
Quality	Percent of people with disabilities served by home and community-based services[2]	94.7%	96.5%	FY2017 to FY20121
Result	Percent of Minnesotans without health insurance[3]	4.7%	4.0%	2019 to 2021
Result	Percent of Low Income Minnesotans without Health Insurance[4]	8.9%	8.5%	2019 to 2021
Quantity	Total number of MHCP enrollees served by an IHP[5] Number of MA program enrollees served by an IHP	428,664 407,900	470,576 437,704	2020 to 2021
Quality	Estimated reduction in health care expenditures (below projections) for providers in Integrated Health Partnership demonstration project[6]	$7.56 million	$27.56 million	2019 to 2020

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. More information is also available at https://mn.gov/dhs/ltss-program-performance (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. More information is also available at https://mn.gov/dhs/ltss-program-performance (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 2015 (Previous) and 2017 (Current)
4. Measure is the percentage of uninsured Minnesotans with family income below 200 percent of poverty. Source: Minnesota Health Access Survey, Minnesota Department of Health. Compares 2015 (Previous) and 2017 (Current).
5. Measure is the number of enrollees served by an IHP provider. Compares 2017 (Previous) and 2020 (Current).
6. Measure is an estimated reduction in annual medical costs below projections for 2017 and 2018 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. This number includes savings to providers, health plans, the federal government, and the state. Integrated Health Partnerships (IHPs) allow participating providers to enter into an arrangement with DHS to care for enrollees under a payment model that holds the participants accountable for the costs and quality of care their Medicaid patients receive. The goal of the program is to improve the quality and value of care provided to Medicaid and MinnesotaCare enrollees while lowering the cost through innovative approaches to care and payment.

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)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	4,960,899	4,731,362	5,040,702	6,056,322	6,586,322	7,179,101	6,680,231	6,612,905
2000 - Restrict Misc Special Revenue	68,951	76,250	94,528	99,247	99,247	99,247	99,247	99,247
2360 - Health Care Access	586,959	602,583	602,596	353,265	869,524	612,099	869,524	1,509,499
3000 - Federal	7,930,368	8,467,680	10,927,628	12,533,124	11,188,819	11,151,322	11,188,819	11,151,322
Total	**13,547,178**	**13,877,875**	**16,665,454**	**19,041,958**	**18,743,912**	**19,041,769**	**18,837,821**	**19,372,973**
Biennial Change				8,282,359		2,078,269		2,503,382
Biennial % Change				30		6		7
Governor's Change from Base								425,113
Governor's % Change from Base								1
Expenditures by Category								
Operating Expenses	233,600	233,240	254,852	312,975	324,447	337,309	319,396	316,348
Grants, Aids and Subsidies	13,313,578	13,644,635	16,410,602	18,728,983	18,419,465	18,704,460	18,518,425	19,056,625
Total	**13,547,178**	**13,877,875**	**16,665,454**	**19,041,958**	**18,743,912**	**19,041,769**	**18,837,821**	**19,372,973**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		513,109						
Direct Appropriation	5,436,831	4,812,335	5,066,799	6,101,549	6,622,937	7,184,580	6,716,846	6,618,384
Transfers In	31,446	31,493	26,291	3,708	1,040	1,040	1,040	1,040
Transfers Out	46,336	47,684	48,536	48,935	37,655	6,519	37,655	6,519
Cancellations	461,042	577,891	3,852					
Expenditures	**4,960,899**	**4,731,362**	**5,040,702**	**6,056,322**	**6,586,322**	**7,179,101**	**6,680,231**	**6,612,905**
Biennial Change in Expenditures				1,404,762		2,668,399		2,196,112
Biennial % Change in Expenditures				14		24		20
Governor's Change from Base								(472,287)
Governor's % Change from Base								(3)
2000 - Restrict Misc Special Revenue								
Balance Forward In	2,648	615	6,434	25	25	25	25	25
Receipts	66,303	76,835	88,120	99,247	99,247	99,247	99,247	99,247
Balance Forward Out		1,200	25	25	25	25	25	25
Expenditures	**68,951**	**76,250**	**94,528**	**99,247**	**99,247**	**99,247**	**99,247**	**99,247**
Biennial Change in Expenditures				48,574		4,719		4,719
Biennial % Change in Expenditures				33		2		2
Governor's Change from Base								0
Governor's % Change from Base								0
2360 - Health Care Access								
Direct Appropriation	586,959	602,583	602,596	353,265	869,524	612,099	869,524	1,509,499
Expenditures	**586,959**	**602,583**	**602,596**	**353,265**	**869,524**	**612,099**	**869,524**	**1,509,499**
Biennial Change in Expenditures				(233,681)		525,762		1,423,162
Biennial % Change in Expenditures				(20)		55		149
Governor's Change from Base								897,400
Governor's % Change from Base								61
3000 - Federal								
Balance Forward In	24,245	943	29,265	34,604	34,604	34,604	34,604	34,604
Receipts	7,958,581	8,484,688	10,932,969	12,533,124	11,188,819	11,151,322	11,188,819	11,151,322
Balance Forward Out	52,457	17,950	34,606	34,604	34,604	34,604	34,604	34,604

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures	**7,930,368**	**8,467,680**	**10,927,628**	**12,533,124**	**11,188,819**	**11,151,322**	**11,188,819**	**11,151,322**
Biennial Change in Expenditures				7,062,704		(1,120,611)		(1,120,611)
Biennial % Change in Expenditures				43		(5)		(5)
Governor's Change from Base								0
Governor's % Change from Base								0

Program: Forecasted Programs
Activity: Alternative Care

https://mn.gov/dhs/people-we-serve/seniors/services/home-community/programs-and-services/alternative-care.jsp
https://mn.gov/dhs/people-we-serve/seniors/services/home-community/programs-and-services/essential-community-supports.jsp

AT A GLANCE

- The Alternative Care Program served 3,681 people, averaging 2,676 enrollees per month with an average monthly benefit of $1,175 in FY21.
- Enrolled consumers contributed a total of $715 thousand towards their cost of care.
- The Essential Community Supports program is included as part of the Alternative Care Budget activity and served 152 enrollees each month with an average monthly benefit of $228 in FY21.
- All funds spending for the Alternative Care activity for FY21 was $38.20 million. This represented 0.19 percent of the Department of Human Services overall budget.

PURPOSE AND 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. AC services support older adults, their families, caregivers and communities to help older adults 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 (MA) long-term services and supports (LTSS) , 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 services, 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, and transportation.

Some people who have a lower level of need for long-term care services do not qualify for Alternative Care or Medical Assistance LTSS. Those people are instead served by the Essential Community Supports (ECS) program. ECS covers 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 $473 a month for these services. This program is included as part of the Alternative Care budget activity. DHS partners with community providers, counties, Tribal Nations and the Department of Health in providing and monitoring services.

The AC program is currently 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. ECS is state funded only.

During the coronavirus (COVID-19) pandemic, DHS has preserved access to health care programs in accordance with Emergency Executive Orders 20-11 and 20-12, and to qualify for a temporary 6.2 percent Federal Medical Assistance Percentage (FMAP) increase authorized by the Families First Coronavirus Response Act (FFCRA).[1] To qualify for the FMAP increase, the state must maintain Medicaid (MA in Minnesota) for all individuals enrolled on and after March 18, 2020, through the end of the month in which the federal public health emergency ends, unless the individual requests a voluntary closure of their coverage, ceases to be a resident of the state or has died. This change applies similarly to Alternative Care. During the 2020 Legislative Session, the Minnesota Legislature codified and extended DHS authority to maintain continuous coverage for MA and Alternative Care programs in order to continue receiving enhanced FMAP in the event the Governor's peacetime emergency expires, terminated or is rescinded.[2] Additionally, Executive Order 20-12 prevented AC enrollees from losing coverage due to a failure to pay premiums.

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 well people who are eligible for publicly funded long-term services and supports access the services in their homes and community rather than in nursing facilities.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Result	Percent of older adults served by home and community-based services[1]	72.8%	79.1%	2017 to 2021
Quantity	Percent of long-term services and support expenditures for older adults spent on home and community-based services[2]	48.3%	52.3%	2017 to 2021
Quantity	Percent of AC spending on Consumer-Directed Community Supports (CDCS)[3]	9.9%	21.6%	FY 2017 to FY 2021

More information is available on Long-Term Service and Support Performance Dashboards (https://mn.gov/dhs/ltss-program-performance)

Performance Notes:

1. This measure shows the percentage of older adults receiving publicly-funded long-term services and supports who receive home and community-based services through the Elderly Waiver, Alternative Care, or home care programs instead of nursing home services. (Source: DHS Data Warehouse)

[1] The Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127). Section 6008 of the FFCRA provides a temporary 6.2 percentage point increase to each qualifying state's Federal Medical Assistance Percentage (FMAP) beginning January 1, 2020, and through the last day of the calendar quarter in which the COVID-19 public health emergency declared by the Secretary of Health and Human Services terminates.

[2] Laws 2020, Special Session 1, Chapter 7 (https://www.revisor.mn.gov/laws/2020/1/Session+Law/Chapter/7/)

2. This measure shows the percentage of public long-term service and support funding for older adults that is spent on Elderly Waiver, Alternative Care or home care services instead of nursing home services. (Source: DHS Data Warehouse).
3. 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 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)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	15,611	15,833	11,611	45,922	45,945	45,981	46,985	50,548
2000 - Restrict Misc Special Revenue	1,498	1,162	1,672	2,211	2,211	2,211	2,211	2,211
3000 - Federal	18,926	21,202	25,328	25,512	23,446	24,918	23,446	24,918
Total	**36,035**	**38,197**	**38,611**	**73,645**	**71,602**	**73,110**	**72,642**	**77,677**
Biennial Change				38,024		32,456		38,063
Biennial % Change				51		29		34
Governor's Change from Base								5,607
Governor's % Change from Base								4
Expenditures by Category								
Operating Expenses	(147)	(97)	33					
Grants, Aids and Subsidies	36,182	38,294	38,578	73,645	71,602	73,110	72,642	77,677
Total	**36,035**	**38,197**	**38,611**	**73,645**	**71,602**	**73,110**	**72,642**	**77,677**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Direct Appropriation	45,246	45,655	35,227	45,922	45,945	45,981	46,985	50,548
Transfers Out	29,635	29,822	23,569					
Cancellations			47					
Expenditures	**15,611**	**15,833**	**11,611**	**45,922**	**45,945**	**45,981**	**46,985**	**50,548**
Biennial Change in Expenditures				26,089		34,393		40,000
Biennial % Change in Expenditures				83		60		70
Governor's Change from Base								5,607
Governor's % Change from Base								6
2000 - Restrict Misc Special Revenue								
Balance Forward In	290	170	487					
Receipts	1,208	992	1,186	2,211	2,211	2,211	2,211	2,211
Expenditures	**1,498**	**1,162**	**1,672**	**2,211**	**2,211**	**2,211**	**2,211**	**2,211**
Biennial Change in Expenditures				1,223		539		539
Biennial % Change in Expenditures				46		14		14
Governor's Change from Base								0
Governor's % Change from Base								0
3000 - Federal								
Balance Forward In	58	76	132	73	73	73	73	73
Receipts	18,921	21,216	25,268	25,512	23,446	24,918	23,446	24,918
Balance Forward Out	53	90	73	73	73	73	73	73
Expenditures	**18,926**	**21,202**	**25,328**	**25,512**	**23,446**	**24,918**	**23,446**	**24,918**
Biennial Change in Expenditures				10,712		(2,476)		(2,476)
Biennial % Change in Expenditures				27		(5)		(5)
Governor's Change from Base								0
Governor's % Change from Base								0

Program: Forecasted Programs
Activity: Behavioral Health Fund

https://mn.gov/dhs/people-we-serve/adults/health-care/alcohol-drugs-addictions/programs-and-services/

AT A GLANCE

- In the United States, 20.3 million people aged 12 and older had substance use disorders (CY21) according to the Substance Abuse and Mental Health Services Administration (SAMHSA).
- About 277,000 people aged 12 or older in Minnesota were estimated to have a substance use disorder in the past year, according to 2018-2019 National Survey on Drug Use and Health data.
- Statewide, there were 58,563 admissions for substance use disorder (SUD) treatment in FY21.
- FY20 SUD service claims amounts totaled over $60 million paid by Medicaid and over $61 million paid by the Behavioral Health Fund.
- The percentage of people completing substance use disorder was 46 percent in FY 2021.
- All funds spending for the Behavioral Health Fund activity for FY19 was $194 million, which represents 0.95 percent of the Department of Human Services overall budget.

PURPOSE AND CONTEXT

The Behavioral Health Fund activity pays for residential and outpatient substance use disorder (SUD) treatment services for eligible low-income Minnesotans.

Legislation passed in 2017 set the direction to move from the longstanding Rule 25 process to Direct Access. As of October 2020, system changes allowed an individual to choose Direct Access or the legacy Rule 25 process. Both processes include county/tribal responsibility to determine financial eligibility under Rule 24.

As of July 1, 2022, Direct Access is the only way to access SUD treatment services in Minnesota. Individuals directly access Comprehensive Assessment at the provider of their choice. The provider determines if current funding is in place. If not, the provider assists the individual to contact the county (or tribe) of residence to determine financial eligibility for the Behavioral Health Fund (BHF). BHF household size and income eligibility guidelines are similar to Medical Assistance (MN Medicaid) guidelines, but are calculated prospectively, as of the date the Comprehensive Assessment was provided. If the person meets clinical and financial eligibility guidelines, the person has choice of the treating provider, funded by the BHF.

SERVICES PROVIDED

The Behavioral Health Fund is fee-for-service funding for residential and outpatient substance use disorder treatment services for eligible low-income Minnesotans. The BHF combines multiple funding sources – state appropriations, county share, and a portion of the federal Substance Abuse, Prevention and Treatment block grant. 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. There is no county share for Medicaid recipients. Counties pay 22.95% of treatment service claims for non-MA recipients.

All programs are enrolled as Minnesota Health Care Programs and 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.

SUD 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*** (1)	***Previous (CY2019)***	***Current (CY2021)***	***Dates***
Quantity	Number of treatment admissions to substance use disorder treatment	64,166	58,563*	2019 to 2021
Result	Percent of persons completing substance use disorder treatment	50.5%	46%	2019 to 2021
Result	Effect of recovery environment on non-completion rates in substance use disorder treatment (2) No severity vs. extreme severity	N/A	3.45% vs. 30.07%	2021

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.
2. Recovery environment (encompassing health, home, community and purpose) is a predictable measure of successful treatment and continued recovery. CY18 baseline data 5% to 25.7%.
3. * Decrease in admissions likely due to the COVID-19 pandemic and associated limitations.

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. Minnesota Rules, parts 9530.7000 to 9530.7031 https://www.revisor.mn.gov/rules/9530.7000 (Rule 24) provides specific guidance with definitions, edibility guidelines, local agency responsibility, and related processes.

Behavioral Health Fund

Activity Expenditure Overview

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General		37,201					351	350
2000 - Restrict Misc Special Revenue	189,716							
2001 - Other Misc Special Revenue		156,926	160,006	221,332	212,140	218,683	212,140	218,683
Total	**189,716**	**194,127**	**160,006**	**221,332**	**212,140**	**218,683**	**212,491**	**219,033**
Biennial Change				(2,506)		49,485		50,186
Biennial % Change				(1)		13		13
Governor's Change from Base								701
Governor's % Change from Base								0
Expenditures by Category								
Grants, Aids and Subsidies	189,716	194,127	160,006	221,332	212,140	218,683	212,491	219,033
Total	**189,716**	**194,127**	**160,006**	**221,332**	**212,140**	**218,683**	**212,491**	**219,033**

(Dollars in Thousands)

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY20	FY21	FY22	FY23	FY24	FY25	FY24	FY25
1000 - General								
Direct Appropriation	113,748	107,412	84,363	88,881	96,387	98,417	96,738	98,767
Transfers In		39,230		27				
Transfers Out	107,943	109,441	84,363	88,908	96,387	98,417	96,387	98,417
Cancellations	5,805							
Expenditures		**37,201**					**351**	**350**
Biennial Change in Expenditures				(37,201)		0		701
Biennial % Change in Expenditures								
Governor's Change from Base								701
Governor's % Change from Base								
2000 - Restrict Misc Special Revenue								
Balance Forward In	6,154	3,842						
Receipts	50,978							
Transfers In	132,748							
Transfers Out		3,842						
Balance Forward Out	164							
Expenditures	**189,716**							
Biennial Change in Expenditures				(189,716)		0		0
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								
2001 - Other Misc Special Revenue								
Balance Forward In			1,028	8,361				
Receipts		78,889	82,976	124,590	116,253	120,766	116,253	120,766
Transfers In		113,283	84,363	88,881	96,387	98,417	96,387	98,417
Transfers Out		35,247		500	500	500	500	500
Balance Forward Out			8,361					
Expenditures		**156,926**	**160,006**	**221,332**	**212,140**	**218,683**	**212,140**	**218,683**
Biennial Change in Expenditures				224,412		49,485		49,485
Biennial % Change in Expenditures						13		13
Governor's Change from Base								0
Governor's % Change from Base								0

Program: Grant Programs
Activity: Support Services Grants

https://mn.gov/dhs/partners-and-providers/program-overviews/economic-supports-cash-food/
https://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 21,700 people per month.
- Provides Supplemental Nutrition Assistance Program employment services to approximately 700 people per month.
- All funds spending for the Support Services Grants activity for FY 2021 was $104 million. This represented 0.59 percent of the Department of Human Services overall budget.

PURPOSE AND CONTEXT

The Minnesota Family Investment Program (MFIP) and Diversionary Work Program (DWP) primary focus is on self-sufficiency through employment.

Support Services Grants cover the cost of services to address barriers, help stabilize families and adults, and build skills that ensure participants are prepared to find and retain employment.

SERVICES PROVIDED

The Support Services Grants activity provides funding for the MFIP Consolidated Fund and for the SNAP Employment and Training Program:

- **MFIP Consolidated Fund:** 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. 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.

Workforce Centers, counties, Tribal Nations, and community agencies provide employment services. 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.

SNAP Employment and Training: Federal SNAP Employment and Training funds are allocated to counties and used to provide a basic foundation of employment services that, if enhanced with local or other state funds, can earn a 50 percent reimbursement to build greater capacity. Support Services Grants to SNAP Employment and Training programs are matched through federal reimbursement.

RESULTS

The two key measures in MFIP/DWP are:

- The **Self-Support Index** is a results measure. The Self-Support Index 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***
2010	67.0%
2011	65.2%
2012	65.3%
2013	66.9%
2014	68.5%
2015	68.8%
2016	68.0%
2017	65.9%
2018	64.6%
2019	64.4%
2020	65.7%
2021	64.6%

- The federal Work Participation Rate (WPR) is a process measure and counts the number of parents engaging in a minimum number of hours of federally-recognized work activities. The measure does not count households who discontinue assistance when getting a job.

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%
2016	39.4%
2017	38.9%
2018	37.2%
2019	35.7%
2020	22.3%

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. NOTE: The Diversionary Work Program (DWP) was suspended due to COVID-19 during the state peacetime emergency from April 2020 to August 2021.

Calendar Year	*Median Placement Wage Per Hour for MFIP Clients*	*Median Placement Wage Per Hour for DWP Clients*
2008	$9.00	$9.39
2009	$9.00	$9.30
2010	$9.50	$9.50
2011	$9.50	$9.50
2012	$9.95	$10.00
2013	$10.00	$10.00
2014	$10.29	$10.00
2015	$11.00	$11.00
2016	$11.50	$11.50
2017	$12.00	$12.00
2018	$12.50	$13.00
2019	$13.00	$13.00
2020	$14.00	-
2021	$15.00	-

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)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	8,693	8,691	8,692	8,715	8,715	8,715	8,715	8,715
3000 - Federal	3,054	3,062	4,314	11,200	11,200	11,200	11,200	11,200
3001 - Federal TANF	94,701	92,238	88,460	96,311	96,311	96,311	96,311	96,311
Total	**106,449**	**103,991**	**101,466**	**116,226**	**116,226**	**116,226**	**116,226**	**116,226**
Biennial Change				7,252		14,760		14,760
Biennial % Change				3		7		7
Governor's Change from Base								0
Governor's % Change from Base								0
Expenditures by Category								
Operating Expenses	1,136	1,368	597					
Grants, Aids and Subsidies	105,312	102,624	100,869	116,226	116,226	116,226	116,226	116,226
Total	**106,449**	**103,991**	**101,466**	**116,226**	**116,226**	**116,226**	**116,226**	**116,226**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Direct Appropriation	8,715	8,715	8,715	8,715	8,715	8,715	8,715	8,715
Cancellations	22	24	23					
Expenditures	**8,693**	**8,691**	**8,692**	**8,715**	**8,715**	**8,715**	**8,715**	**8,715**
Biennial Change in Expenditures				22		23		23
Biennial % Change in Expenditures				0		0		0
Governor's Change from Base								0
Governor's % Change from Base								0
2000 - Restrict Misc Special Revenue								
Balance Forward In		114	114	114	114	114	114	114
Balance Forward Out		114	114	114	114	114	114	114
3000 - Federal								
Balance Forward In		43						
Receipts	3,054	3,019	4,314	11,200	11,200	11,200	11,200	11,200
Expenditures	**3,054**	**3,062**	**4,314**	**11,200**	**11,200**	**11,200**	**11,200**	**11,200**
Biennial Change in Expenditures				9,398		6,886		6,886
Biennial % Change in Expenditures				154		44		44
Governor's Change from Base								0
Governor's % Change from Base								0
3001 - Federal TANF								
Balance Forward In		57	3,761					
Receipts	94,701	92,181	84,699	96,311	96,311	96,311	96,311	96,311
Expenditures	**94,701**	**92,238**	**88,460**	**96,311**	**96,311**	**96,311**	**96,311**	**96,311**
Biennial Change in Expenditures				(2,168)		7,851		7,851
Biennial % Change in Expenditures				(1)		4		4
Governor's Change from Base								0
Governor's % Change from Base								0

Program: Grant Programs
Activity: Basic Sliding Fee Child Care Assistance Grants

https://mn.gov/dhs/people-we-serve/children-and-families/economic-assistance/child-care/programs-and-services/basic-sliding-fee.jsp

AT A GLANCE

- In SFY21 Basic Sliding Fee Child Care Assistance paid for childcare for 12,209 children in 6,186 families in an average month.
- As of May 2022, there was a waiting list of 445 families eligible for assistance but unable to be served at the current funding levels.
- The average monthly assistance per family was $1,427.
- All funds spending for the BSF Child Care Assistance Grants activity for FY 2021 was $125 million. This represented 0.6 percent of the Department of Human Services overall budget.

PURPOSE AND CONTEXT

In order to work, families need safe and reliable childcare. The annual cost of full-time care for one child ranges from $9,000 to $19,000 per year, depending on the age of the child, location, and type of provider attended. Many low-income families struggle to find affordable childcare that fits their needs. Basic Sliding Fee (BSF) Child Care Assistance provides financial subsidies to help low-income families pay for childcare through the Child Care Assistance Program. Families earning no more than 47 percent of the state median income ($44,589 in 2022 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 ($63,564 in 2020 for a family of three) or when their copayment exceeds their cost of care.

SERVICES PROVIDED

BSF childcare assistance grants provide support to help improve outcomes for the most at-risk children and their families by increasing access to high quality childcare.

Families must be working, looking for work or attending school to be eligible for the Basic Sliding Fee Program. The program helps families pay childcare costs on a sliding fee basis. As family income increases, so does the amount of childcare expenses (copayment) paid by the family. All families receiving childcare 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 ($52,179) would have a total biweekly copayment of $168 for all children in care.

The BSF childcare 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: childcare centers, family childcare, and legal non-licensed childcare. Providers are paid at the rate they charge in the private childcare 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.

Childcare must be provided by a legal childcare provider over the age of 18 years. Allowable providers include legal non-licensed family childcare, license-exempt centers, licensed family childcare, and licensed childcare centers. Families choose their providers in the private childcare market. Counties administer the Child Care Assistance Program.

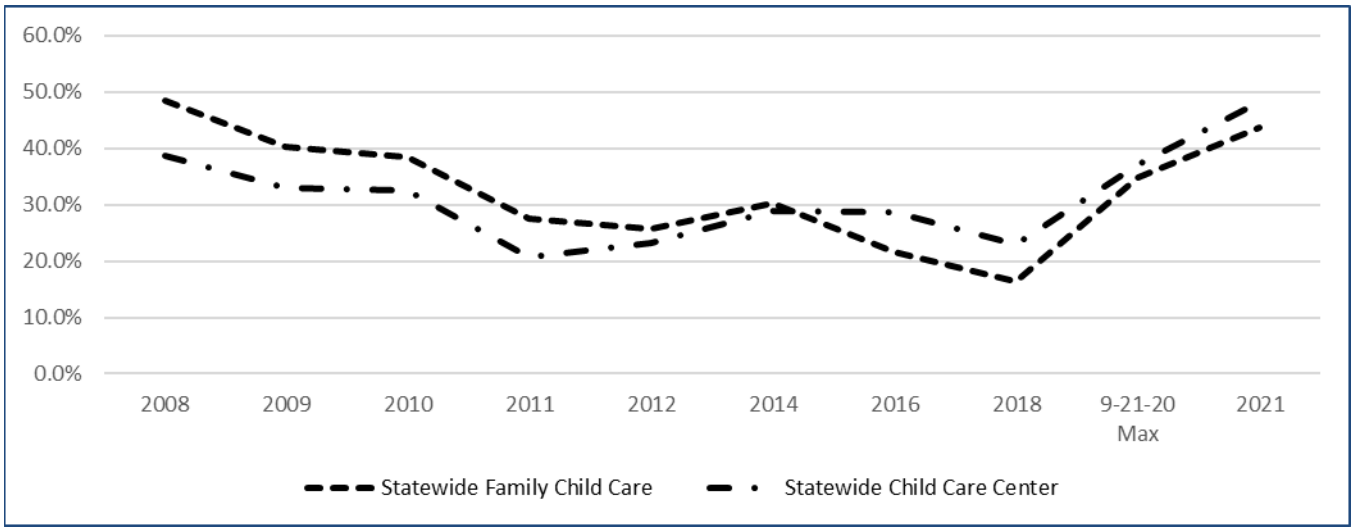
BSF funding is a capped allocation. It includes a combination of state funds and federal Child Care and Development and Temporary Assistance for Needy Families (TANF) funding. The agency allocates funding to counties, who administer the program. Because the funding is capped, not everyone who is eligible for the program may be served. As of May 2022, there was a waiting list for BSF childcare assistance of 445 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 childcare. 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 childcare providers who charge prices that are fully covered by the Child Care Assistance Program increased when the maximum rates were raised in the 2021 legislative session, but the maximum rate paid remains low compared to prices in the market.**

This quality measure shows approximately 43 percent of family childcare providers and approximately 48 percent of childcare centers charge prices that are fully covered by the Child Care Assistance Program maximum rates.

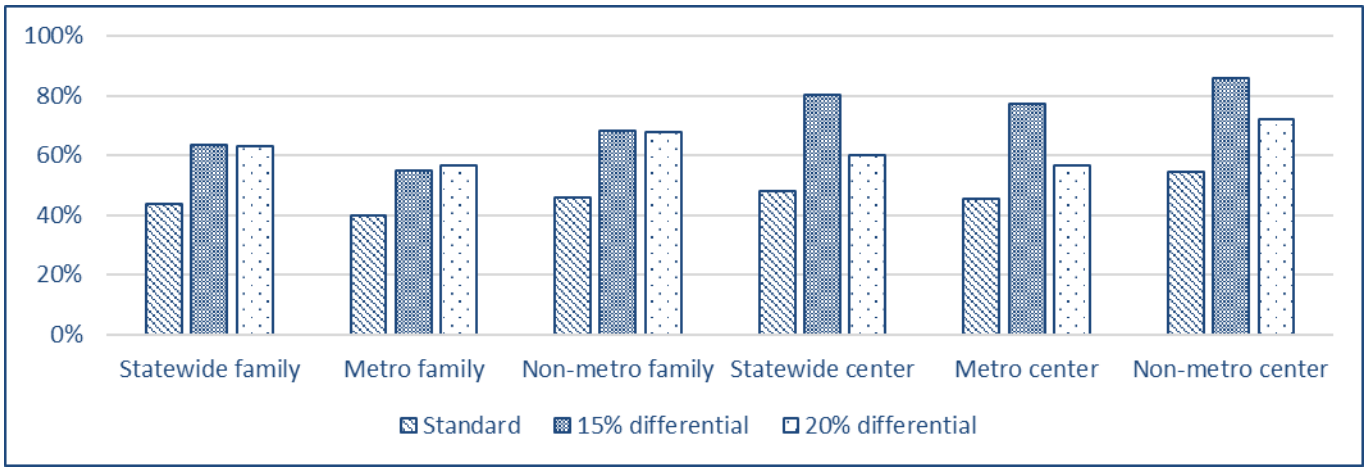
Provider prices fully covered by Standard Maximum Rates statewide, by percent



Quality Differential Impact - Parent Aware is Minnesota's rating tool for helping parents select high quality childcare 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.

Prices fully covered by Standard and Quality Differential Maximum Rates (November 2021)



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 at a higher proportion compared to 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 childcare assistance through providers eligible for the higher subsidy rates for quality has increased from 37.5 percent in July of 2016 to 52 percent in July of 2021.

Percent of Children Receiving Child Care Assistance in Quality Settings

	2018	2019	2020	2021
Standard Care	57.7%	51.6%	46.6%	44.5%
Provider holds Accreditation*	3.2%	2.8%	2.4%	2.4%
Provider holds Parent Aware 1-2 Star	5.7%	6.3%	4.0%	3.5%
Provider holds Parent Aware 3-4 Star*	33.4%	39.3%	47%	49.6%

** These providers are eligible for CCAP higher rates for quality. Data representative of services provided in July of each year.*

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 MEC^2, Minnesota's childcare 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)

Basic Sliding Fee Child Care Assistance Grants

Activity Expenditure Overview

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	44,655	53,616	53,350	53,362	53,366	53,366	69,203	118,801
3000 - Federal	63,364	54,324	59,524	82,200	97,976	65,768	119,976	73,768
3015 - ARP-State Fiscal Recovery				7,000				
Total	**108,019**	**107,940**	**112,874**	**142,562**	**151,342**	**119,134**	**189,179**	**192,569**
Biennial Change				39,477		15,040		126,312
Biennial % Change				18		6		49
Governor's Change from Base								111,272
Governor's % Change from Base								41
Expenditures by Category								
Operating Expenses			8					
Grants, Aids and Subsidies	108,019	107,940	112,867	142,562	151,342	119,134	189,179	192,569
Total	**108,019**	**107,940**	**112,874**	**142,562**	**151,342**	**119,134**	**189,179**	**192,569**

Basic Sliding Fee Child Care Assistance Grants

Activity Financing by Fund

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Direct Appropriation	44,655	53,616	53,350	53,362	53,366	53,366	69,203	118,801
Expenditures	**44,655**	**53,616**	**53,350**	**53,362**	**53,366**	**53,366**	**69,203**	**118,801**
Biennial Change in Expenditures				8,441		20		81,292
Biennial % Change in Expenditures				9		0		76
Governor's Change from Base								81,272
Governor's % Change from Base								76
3000 - Federal								
Balance Forward In	16,141	12,496	12,988	7,300	7,300	7,300	7,300	7,300
Receipts	59,719	47,344	53,837	82,200	97,976	65,768	119,976	73,768
Balance Forward Out	12,496	5,515	7,300	7,300	7,300	7,300	7,300	7,300
Expenditures	**63,364**	**54,324**	**59,524**	**82,200**	**97,976**	**65,768**	**119,976**	**73,768**
Biennial Change in Expenditures				24,036		22,020		52,020
Biennial % Change in Expenditures				20		16		37
Governor's Change from Base								30,000
Governor's % Change from Base								18
3015 - ARP-State Fiscal Recovery								
Direct Appropriation				7,000	0	0	0	0
Expenditures				**7,000**				
Biennial Change in Expenditures				7,000		(7,000)		(7,000)
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								

Program: Grant Programs
Activity: Child Care Development Grants

https://mn.gov/dhs/people-we-serve/children-and-families/services/child-care/

AT A GLANCE

- As of July 2021, 30% of eligible childcare and early education programs have a Parent Aware rating (n = 9,522)
- 2,501 family childcare providers and 10,093 childcare center direct care staff have listed their employment at their childcare program in Develop, Minnesota's Quality Improvement and Registry Tool.
- 2,461 unique individuals received coaching and support services to increase quality of care to children in SFY21.
- All funds spending for the Child Care Development Grants activity for FY21 was $254 million. This represented 1.3 percent of the Department of Human Services overall budget.

PURPOSE AND CONTEXT

Child Care Development Grants provide a system of quality improvement supports for licensed childcare programs, professional development supports for the childcare workforce, and information and supports for prospective childcare business owners to improve the supply of childcare. They also support families to find care and education to meet their needs.

These grants are foundational to DHS' strategy for addressing Minnesota's childcare scarcity. The lack of quality childcare, especially in Greater Minnesota, has a tangible economic impact because communities with an adequate supply of childcare are better positioned to attract and retain employees.

In addition, there are too few individuals with the qualifications needed to work in childcare programs, which also contributes to the childcare shortage. These grants help new childcare workforce members gain needed qualifications, and provide grants, loans, training, coaching, and technical assistance that help retain and support the current childcare workforce.

SERVICES PROVIDED

The Department of Human Services (DHS) provides grants to public and private partners who specialize in providing services for childcare providers, families, and individuals working on starting new childcare businesses, to increase the supply and quality of childcare in Minnesota. Services include:

- Information for parents searching for quality childcare and early education for their children through Parent Aware, an online search tool (Parent Aware website, http://www.parentaware.org/) and other parent education services provided by Child Care Aware of Minnesota
- Grants, loans, financial supports and other incentives to encourage current and prospective childcare providers and teachers to enter the care and education field, stay in it, advance in their profession, and improve their programs through participation in the voluntary Parent Aware Quality Rating and Improvement System
- Training, coaching, professional development advising, and other workforce supports for early childhood and school-age care providers to increase their business skills, knowledge of child development, and instructional practices to meet the needs of individual children
- Reimbursement to childcare programs and providers to cover some of the fees charged to complete a nationally recognized childcare accreditation program

Child Care Development Grants are funded primarily with federal Child Care and Development Block Grant funds and some state general funds.

RESULTS

Part A: Performance Data (Required)

Use of Quality Child Care - Children who participate in quality childcare 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 childcare assistance through providers with Parent Aware Ratings has increased from 50 percent in July 2017 to 65 percent in July 2021.

Number of Programs Rated by Parent Aware – Parent Aware improves children's outcomes by improving families' access to high quality childcare. This measure shows that the percentage of childcare and early education programs with a Parent Aware rating increased from 2019 to 2021.

Provider Education Levels – Childcare 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 education level of early childhood educators has continued to grow over time, as reported by those educators volunteering to verify their education level.

Searches for Quality Care through Parent Aware – The ParentAware.org website is an important resource for families searching for all types of early care and education settings, including childcare, school-based pre-kindergarten programs, and Head Start. The number of unique visitors on this website grew between 2019 to 2021.

Type of Measure	*Description*	*Previous*	*Current*	*Dates*
Result	Percent of children receiving childcare assistance in high quality settings	50%	65%	2017 & 2021
Quantity	Percent of childcare and early education programs with a Parent Aware rating	28%	30%	2019 & 2021
Quantity	Number of family childcare providers and teachers working directly with children with a Credential, CDA or Degree (AAS, BA/BS or higher)	5,267	6,070	2019 & 2021
Quantity	Number of unique visitors on Parent Aware.org	86,359	109,671	2019 & 2021

Part B: Evidence of Effectiveness (Optional)

Evidence-based Practice	**Source of Evidence**	**FY 22-23 Expenditures (if known)**
Parent Aware Quality Rating and Improvement System	Preschool & child care Quality Rating and Improvement Systems (QRIS) | County Health Rankings & Roadmaps (https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/preschool-child-care-quality-rating-and-improvement-systems-qris)	State Fiscal Year 2021 funding for this activity was $11,302,971 in federal Child Care Development Block Grant funds, and $1,242,000 in State General Funds. State Fiscal Year 2022 amount not yet available.

The legal authority for the Child Care Development Grant activities is M.S. chapter 119B (https://www.revisor.mn.gov/statutes/?id=119B).

Child Care Development Grants

Activity Expenditure Overview

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	32,917	2,948	2,937	2,962	2,962	2,962	168,812	173,127
2001 - Other Misc Special Revenue	413	1,521	2,518	3,237				
3000 - Federal	30,719	114,772	190,416	219,918	279,201	254,305	279,201	254,305
3010 - Coronavirus Relief		139,657						
3015 - ARP-State Fiscal Recovery			19,969					
Total	**64,049**	**258,898**	**215,840**	**226,117**	**282,163**	**257,267**	**448,013**	**427,432**
Biennial Change				119,009		97,473		433,488
Biennial % Change				37		22		98
Governor's Change from Base								336,015
Governor's % Change from Base								62
Expenditures by Category								
Operating Expenses	899	946	548	1,824	100	100	100	100
Grants, Aids and Subsidies	63,150	257,953	215,291	224,293	282,063	257,167	447,913	427,332
Total	**64,049**	**258,898**	**215,840**	**226,117**	**282,163**	**257,267**	**448,013**	**427,432**
Total Agency Expenditures	64,049	258,898	215,840	226,117	282,163	257,267	448,013	427,432
Internal Billing Expenditures	(10)							
Expenditures Less Internal Billing	**64,059**	**258,898**	**215,840**	**226,117**	**282,163**	**257,267**	**448,013**	**427,432**

Child Care Development Grants

Activity Financing by Fund

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In	0	0						
Direct Appropriation	31,701	1,737	1,737	1,737	1,737	1,737	167,587	171,902
Transfers In	1,225	1,225	1,225	1,225	1,225	1,225	1,225	1,225
Cancellations	9	14	25					
Expenditures	**32,917**	**2,948**	**2,937**	**2,962**	**2,962**	**2,962**	**168,812**	**173,127**
Biennial Change in Expenditures				(29,966)		25		336,040
Biennial % Change in Expenditures				(84)		0		5,697
Governor's Change from Base								336,015
Governor's % Change from Base								5,672
2001 - Other Misc Special Revenue								
Balance Forward In		55						
Receipts	422	1,465	2,518	3,237				
Balance Forward Out	9							
Expenditures	**413**	**1,521**	**2,518**	**3,237**				
Biennial Change in Expenditures				3,821		(5,755)		(5,755)
Biennial % Change in Expenditures				198		(100)		(100)
Governor's Change from Base								0
Governor's % Change from Base								
3000 - Federal								
Balance Forward In			71,053					
Receipts	30,719	185,825	119,363	219,918	279,201	254,305	279,201	254,305
Balance Forward Out		71,053						
Expenditures	**30,719**	**114,772**	**190,416**	**219,918**	**279,201**	**254,305**	**279,201**	**254,305**
Biennial Change in Expenditures				264,843		123,172		123,172
Biennial % Change in Expenditures				182		30		30
Governor's Change from Base								0
Governor's % Change from Base								0
3010 - Coronavirus Relief								
Direct Appropriation		139,671						
Cancellations		14						

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures		**139,657**						
Biennial Change in Expenditures				(139,657)		0		0
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								

3015 - ARP-State Fiscal Recovery

Direct Appropriation			20,000					
Cancellations			31					
Expenditures			**19,969**					
Biennial Change in Expenditures				19,969		(19,969)		(19,969)
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								

Program: Grant Programs
Activity: Child Support Enforcement Grants

https://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 314,000 custodial and non-custodial parents and their 220,000 children.
- In FY 2021, the child support program collected and disbursed $551 million in child support payments.
- Access and visitation funds served 1,070 children in 2021.
- All Funds spending for the Child Support Enforcement Grants Activity for FY 2021 was $1.7 million. This represented less than 0.1 percent of the Department of Human Services overall budget.

PURPOSE AND 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 $551 million in child support payments in FY 2021. 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. Ten percent of cases are currently on public assistance and 40.3 percent of cases were formerly on public assistance. Eighty-eight percent of custodial parents who are eligible for child support are women. The program disproportionately serves parents of color. African American parents account for 24 percent of the child support caseload and American Indian parents account for six percent even though African American and American Indian Minnesotans only account for seven and three percent of the general population.

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 assist custodial parents in obtaining basic support, medical support, and childcare 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 by using digital marketing to increase participation in the child support program. 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 five dollars for every dollar spent on the child support program.

In 2019 Minnesota earned $11.7 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 Measures[1]***	***FFY[2] 2021***	***FFY 2020***	***FFY 2019***	***FFY 2018***	***FFY 2017***
Quantity	Paternities established: percent of children born outside marriage for whom paternity was established in open child support cases for the year	98%	100%[3]	100%	101%	101%
Quantity	Orders established: percent of cases open at the end of the year with orders established	86%	87%	88%	88%	88%
Quantity	Collections on current support: percent of cases with current support due within the year that had a collection on current support	75%	75%	75%	74%	73%
Quantity	Collections on arrears: percent of cases with arrears due within the year that had a collection on arrears	72%	79%	72%	72%	72%
Quality	Cost effectiveness: dollars collected per dollar spent	$3.09	$3.26	$3.14	$3.26	$3.30

Evidence-based Practice	***Source of Evidence***	***FY 22-23 Expenditures (if known)***
Driver's License Suspension Procedural Justice Project	Pilot that started in Fall 2021, ended in Spring 2022. MMB-MAD conducting an evaluation report that will be available in Spring 2023.	No current costs in regards to the evaluation report. Based upon finding(s) of the evaluation report there may be action steps taken to address the findings which may have future costs.

Notes on Performance Measures:

1. Federal performance measures are listed in the 2019 Minnesota Child Support Performance Report (https://www.leg.state.mn.us/docs/2020/other/200610.pdf) https://www.lrl.mn.gov/docs/2022/other/220351.pdf.
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; https://www.govinfo.gov/content/pkg/USCODE-2011-title42/html/USCODE-2011-title42-chap7-subchapIV-partD.htm).

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).

Child Support Enforcement Grants

Activity Expenditure Overview

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
2000 - Restrict Misc Special Revenue	1,663	1,569	1,429	1,509	1,509	1,509	1,509	1,509
2001 - Other Misc Special Revenue	(43)	(14)	72	50	50	50	50	50
3000 - Federal	168	435	580	1,756	3,859	3,213	3,859	3,213
Total	**1,788**	**1,990**	**2,082**	**3,315**	**5,418**	**4,772**	**5,418**	**4,772**
Biennial Change				1,619		4,793		4,793
Biennial % Change				43		89		89
Governor's Change from Base								0
Governor's % Change from Base								0
Expenditures by Category								
Operating Expenses	(270)	9	147	986	3,039	2,393	3,039	2,393
Grants, Aids and Subsidies	2,058	1,981	1,935	2,329	2,379	2,379	2,379	2,379
Total	**1,788**	**1,990**	**2,082**	**3,315**	**5,418**	**4,772**	**5,418**	**4,772**

Child Support Enforcement Grants

Activity Financing by Fund

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Direct Appropriation	50	50	50	50	50	50	50	50
Transfers Out	50	50	50	50	50	50	50	50
2000 - Restrict Misc Special Revenue								
Balance Forward In	60	60	20					
Receipts	1,697	1,603	1,463	1,543	1,543	1,543	1,543	1,543
Transfers Out	34	74	54	34	34	34	34	34
Balance Forward Out	60	20	0					
Expenditures	**1,663**	**1,569**	**1,429**	**1,509**	**1,509**	**1,509**	**1,509**	**1,509**
Biennial Change in Expenditures				(294)		80		80
Biennial % Change in Expenditures				(9)		3		3
Governor's Change from Base								0
Governor's % Change from Base								0
2001 - Other Misc Special Revenue								
Balance Forward In	356	450	516	494	494	494	494	494
Receipts	0							
Transfers In	50	50	50	50	50	50	50	50
Balance Forward Out	449	514	494	494	494	494	494	494
Expenditures	**(43)**	**(14)**	**72**	**50**	**50**	**50**	**50**	**50**
Biennial Change in Expenditures				179		(22)		(22)
Biennial % Change in Expenditures				(315)		(18)		(18)
Governor's Change from Base								0
Governor's % Change from Base								0
3000 - Federal								
Receipts	168	435	580	1,756	3,859	3,213	3,859	3,213
Expenditures	**168**	**435**	**580**	**1,756**	**3,859**	**3,213**	**3,859**	**3,213**
Biennial Change in Expenditures				1,734		4,736		4,736
Biennial % Change in Expenditures				288		203		203
Governor's Change from Base								0
Governor's % Change from Base								0

Program: Grant Programs
Activity: Children's Services Grants

https://mn.gov/dhs/people-we-serve/children-and-families/services/child-protection/

AT A GLANCE

In 2021:

- 24,583 assessments and investigations of child abuse and neglect involving 32,347 children were finalized.
- Of these, 5,606 unique children were determined to be victims of child maltreatment.
- 12,312 children/youth experienced an out-of-home placement.
- All funds spending for the Children's Services Grants activity for FY 2021 was $74 million. This represented 0.3 percent of the Department of Human Services overall budget.

PURPOSE AND CONTEXT

Strong families and communities are 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, become involved in criminal activities and abuse or neglect their own children. Long-term intervention costs for crime, corrections, truancy, hospitalization, special education, and mental health care are also minimized when programs and services support strong families and communities. 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 fund county, tribal, and community-based child welfare services around the state, including Indian child welfare services, child protection, homeless youth services, and child abuse and neglect services. These grants help keep children out of foster care and safely with their families and reduce disparities in the number of children of color in out-of-home placements. 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.
- Design and develop tribal approaches that ensure child safety and permanency.
- Transfer responsibility from counties to tribes to deliver a full continuum of child welfare services to American Indian children and families on two reservations.
- These services are essential to keep 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 meet or exceed most federal standards. Efforts to engage families early and collaboratively with evidence-based interventions have resulted in improved safety and timely permanency outcomes.

Type of Measure	*Name of Measure*	*2016*	*2017*	*2018*	*2019*	*2020*	*2021*
Quality	Percent of children not experiencing repeated abuse or neglect within 12 months of a prior report	91.8%	91.0%	91.0%	93.8%	94.5%	94.2%
Quality	Percent of all children who enter foster care in the previous year that are discharged to permanency (i.e., reunification with parents, caregivers, living with relative, guardianship, adoption) within 12 months	50.6%	47.5%	48.6%	49.5%	46.0%	48.7%
Quality	Percent of all children in foster care who had been in care between 12 and 23 months on the first day of the year that were discharged to permanency within 12 months of the first day of the year	48.1%	51.2%	58.9%	55.5%	52.4%	54.3%
Quality	Percent of all children in foster care who had been in care for 24 months or more on the first day of the year that were discharged to permanency within 12 months of the first day of the year	25.2%	28.8%	34.0%	33.3%	32.4%	37.7%

Performance Measures notes:

Measures from the Child Safety and Permanency Division at the Department of Human Services.

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 260E(Ch. 260E MN Statutes)

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	42,455	48,174	49,412	47,555	47,555	47,555	79,211	100,610
2000 - Restrict Misc Special Revenue	283	1,360	179	611	611	611	611	611
2001 - Other Misc Special Revenue	2,129	2,856	1,712	8,946	8,164	8,164	8,164	8,164
2403 - Gift				1	1	1	1	1
3000 - Federal	21,795	26,989	34,631	52,328	36,219	36,391	36,219	36,391
3001 - Federal TANF	140	140	140	140	140	140	140	140
Total	**66,801**	**79,518**	**86,075**	**109,581**	**92,690**	**92,862**	**124,346**	**145,917**
Biennial Change				49,336		(10,104)		74,607
Biennial % Change				34		(5)		38
Governor's Change from Base								84,711
Governor's % Change from Base								46
Expenditures by Category								
Operating Expenses	606	1,169	1,419	256	256	256	256	256
Grants, Aids and Subsidies	66,196	78,349	84,656	109,325	92,434	92,606	124,090	145,661
Total	**66,801**	**79,518**	**86,075**	**109,581**	**92,690**	**92,862**	**124,346**	**145,917**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In	806	1,022	667	895				
Direct Appropriation	44,207	49,285	52,653	52,368	52,368	52,368	84,024	105,423
Transfers In	334	636	829					
Transfers Out	1,816	2,118	2,311	5,708	4,813	4,813	4,813	4,813
Cancellations	54	652	1,531					
Balance Forward Out	1,022		895					
Expenditures	**42,455**	**48,174**	**49,412**	**47,555**	**47,555**	**47,555**	**79,211**	**100,610**
Biennial Change in Expenditures				6,339		(1,857)		82,854
Biennial % Change in Expenditures				7		(2)		85
Governor's Change from Base								84,711
Governor's % Change from Base								89
2000 - Restrict Misc Special Revenue								
Balance Forward In	1,116	1,653	902	1,236	1,302	1,338	1,302	1,338
Transfers In	760	675	585	750	720	720	720	720
Transfers Out	41	66	73	73	73	73	73	73
Balance Forward Out	1,553	902	1,236	1,302	1,338	1,374	1,338	1,374
Expenditures	**283**	**1,360**	**179**	**611**	**611**	**611**	**611**	**611**
Biennial Change in Expenditures				(852)		432		432
Biennial % Change in Expenditures				(52)		55		55
Governor's Change from Base								0
Governor's % Change from Base								0
2001 - Other Misc Special Revenue								
Balance Forward In	66	185	1,197	967	1,456	1,996	1,456	1,996
Receipts		(31)		3,727	3,891	3,392	3,891	3,392
Transfers In	2,127	2,814	1,482	5,708	4,813	4,813	4,813	4,813
Balance Forward Out	64	113	967	1,456	1,996	2,037	1,996	2,037
Expenditures	**2,129**	**2,856**	**1,712**	**8,946**	**8,164**	**8,164**	**8,164**	**8,164**
Biennial Change in Expenditures				5,673		5,670		5,670
Biennial % Change in Expenditures				114		53		53
Governor's Change from Base								0
Governor's % Change from Base								0

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
2403 - Gift								
Balance Forward In	1	1	1	1	1	1	1	1
Receipts	0	0	0	1	1	1	1	1
Balance Forward Out	1	1	1	1	1	1	1	1
Expenditures				**1**	**1**	**1**	**1**	**1**
Biennial Change in Expenditures				1		1		1
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								0
3000 - Federal								
Balance Forward In	111	0	0	1,424				
Receipts	21,801	26,989	36,056	50,904	36,219	36,391	36,219	36,391
Balance Forward Out	117		1,424					
Expenditures	**21,795**	**26,989**	**34,631**	**52,328**	**36,219**	**36,391**	**36,219**	**36,391**
Biennial Change in Expenditures				38,175		(14,349)		(14,349)
Biennial % Change in Expenditures				78		(17)		(17)
Governor's Change from Base								0
Governor's % Change from Base								0
3001 - Federal TANF								
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
Governor's Change from Base								0
Governor's % Change from Base								0

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

In 2021:

- 24,583 assessments and investigations of child abuse and neglect involving 32,347 children were finalized.
- 1,719 children were either adopted or had a permanent transfer of legal custody to a relative.
- 57,180 reports of suspected maltreatment of a vulnerable adult were received, screened, and dispatched.
- 27,969 reports of suspected maltreatment of a vulnerable adult were assessed by a county.
- 7,962 reports of suspected maltreatment of a vulnerable adult were investigated by a county.
- All funds spending for the Children & Community Services activity for FY 2019 was $94 million. This represented 0.5 percent of the Department of Human Services overall budget.

PURPOSE AND 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 supports counties' administrative responsibility for child protection services and foster care. The funding also helps counties 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 maltreatment, 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.

These grants include state funds and the federal Social Services Block Grant and are allocated to counties through the state's Vulnerable Children and Adult Act.

This budget activity also includes a smaller set of grant funds to support initiatives by the White Earth Nation and Red Lake Nation to operate their own human service systems.

RESULTS

The Department of Human Services monitors the performance of counties in delivering child welfare and adult protective services. Minnesota outcomes meet or exceed most federal child welfare standards. Efforts to engage families early and collaboratively with evidence-based interventions have resulted in improved safety and timely permanency outcomes for children.

Type of Measure	*Name of Measure*	*2014*	*2015*	*2016*	*2017*	*2018*	*2019*	*2020*	*2021*
Quality	Percent of children not experiencing repeated abuse or neglect within 12 months of a prior report	94.3%	94.5%	91.8%	91.0%	91.0%	93.8%	94.5%	94.2%
Quality	Percent of all children who enter foster care in the previous year that are discharged to permanency (i.e., reunification with parents, caregivers, living with relative, guardianship, adoption) within 12 months	60.0%	56.1%	50.6%	47.5%	48.6%	49.5%	46.0%	48.7%
Quality	Percent of all children in foster care who had been in care between 12 and 23 months on the first day of the year that were discharged to permanency within 12 months of the first day of the year	50.0%	44.8%	48.1%	51.2%	58.9%	55.5%	52.4%	54.3%
Quality	Percent of all children in foster care who had been in care for 24 months or more on the first day of the year that were discharged to permanency within 12 months of the first day of the year	17.4%	23.1%	25.2%	28.8%	34.0%	33.3%	32.4%	37.7%

Performance Measures notes:
Measures provided by the Child Safety and Permanency Division at the Department of Human Services.

Also see the DHS Child Welfare Data Dashboard (https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/child-protection-foster-care-adoption/child-welfare-data-dashboard/).

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)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	59,201	59,575	59,353	60,856	60,856	60,856	60,856	60,856
2005 - Opiate Epidemic Response		2,511	4,003	25,391	3,021	11,440	3,021	9,973
3000 - Federal	30,353	30,151	30,498	39,590	39,590	39,590	39,590	39,590
Total	**89,554**	**92,237**	**93,854**	**125,837**	**103,467**	**111,886**	**103,467**	**110,419**
Biennial Change				37,900		(4,338)		(5,805)
Biennial % Change				21		(2)		(3)
Governor's Change from Base								(1,467)
Governor's % Change from Base								(1)
Expenditures by Category								
Operating Expenses	(35)							
Grants, Aids and Subsidies	89,589	92,237	93,854	125,837	103,467	111,886	103,467	110,419
Total	**89,554**	**92,237**	**93,854**	**125,837**	**103,467**	**111,886**	**103,467**	**110,419**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Direct Appropriation	59,201	59,701	61,251	60,856	60,856	60,856	60,856	60,856
Cancellations		126	1,898					
Expenditures	**59,201**	**59,575**	**59,353**	**60,856**	**60,856**	**60,856**	**60,856**	**60,856**
Biennial Change in Expenditures				1,433		1,503		1,503
Biennial % Change in Expenditures				1		1		1
Governor's Change from Base								0
Governor's % Change from Base								0
2005 - Opiate Epidemic Response								
Direct Appropriation		2,790	4,898	25,391	3,021	11,440	3,021	9,973
Cancellations		279	895					
Expenditures		**2,511**	**4,003**	**25,391**	**3,021**	**11,440**	**3,021**	**9,973**
Biennial Change in Expenditures				26,883		(14,933)		(16,400)
Biennial % Change in Expenditures						(51)		(56)
Governor's Change from Base								(1,467)
Governor's % Change from Base								(10)
3000 - Federal								
Balance Forward In	23							
Receipts	30,330	30,151	30,498	39,590	39,590	39,590	39,590	39,590
Expenditures	**30,353**	**30,151**	**30,498**	**39,590**	**39,590**	**39,590**	**39,590**	**39,590**
Biennial Change in Expenditures				9,584		9,092		9,092
Biennial % Change in Expenditures				16		13		13
Governor's Change from Base								0
Governor's % Change from Base								0

SNAP (https://mn.gov/dhs/people-we-serve/children-and-families/economic-assistance/food-nutrition/programs-and-services/supplemental-nutrition-assistance-program.jsp)
Economic Opportunity (https://mn.gov/dhs/partners-and-providers/program-overviews/economic-supports-cash-food/office-of-economic-opportunity/)

AT A GLANCE

- More than 445,000 Minnesotans receive help through the Supplemental Nutrition Assistance Program (SNAP) every month with an average monthly benefit of $190 per person.
- More than 10,500 people receive emergency shelter and services annually
- More than 1,400 individuals receive Transitional Housing Program services annually
- Family Assets for Independence in Minnesota (FAIM) has helped people save nearly $4.65 million and acquire over 2,500 long-term financial assets since 1998.
- All funds spending for the Child & Economic Support Grants activity for FY 2021 was $1.3 billion. This represented 6.5 percent of the Department of Human Services overall budget.

PURPOSE AND CONTEXT

People living in poverty often face numerous barriers and have complex needs. The Department of Human Services administers nearly 200 grants annually to more than 100 organizations to help people in poverty meet their basic needs for food, clothing, and shelter through the Children and Economic Support Grants. Funds are also used to help people get the skills and knowledge to improve their economic stability. 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.

SERVICES PROVIDED

Children and Economic Support Grants fund food, housing, poverty reduction, and financial capability services for low-income families and individuals. These services are designed to:

- Help people buy food
- Ensure people eligible for SNAP know about the program
- Educate people on nutrition and food preparation
- Help legal non-citizens 50 years and older who do not qualify for federal SNAP due to citizenship status purchase food
- Fund food banks, food shelves and on-site meal programs
- Help homeless individuals and families to find safe and stable housing
- Provide supportive services to people experiencing long-term homelessness
- Provide emergency shelter and essential services for homeless adults, children, and youth
- Provide specialized emergency shelter and services for youth who have been victims of sex trafficking
- Fund, train, and provide 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 SNAP funding, other funding sources include state grants, federal grants from the U.S. Departments of Agriculture (USDA), Health and Human Services (HHS), Housing and Urban Development (HUD) and private foundations.

RESULTS

Several programs, such as the Transitional Housing Program and Homeless Youth Act help people with their shelter needs.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Results	Percent of Transitional Housing Program participants that moved into permanent housing	77%	73%	2020 2021
Results	Percent of BIPOC Transitional Housing Program participants that moved into permanent housing	75%	71%	2020 2021
Quality	Percent of Transitional Housing Program participants experiencing long-term homelessness that moved into permanent housing	64%	68%	2020 2021
Quantity	Number of youth heads of household served in Homeless Youth Act-funded emergency shelter or housing	1,265	1,758	2020 2021

Measures provided by Economic Assistance & Employment Support Division at the Department of Human Services.

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)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	58,721	23,116	28,910	33,334	32,740	32,740	89,859	77,109
1251 - COVID-19 Minnesota		4,446						
2000 - Restrict Misc Special Revenue	140	138	140	140	140	140	140	140
2001 - Other Misc Special Revenue	365	182	7					
3000 - Federal	525,876	1,180,901	1,248,996	1,614,476	1,299,174	1,295,352	1,299,174	1,295,352
3010 - Coronavirus Relief	3,668	77,344	21,961					
3015 - ARP-State Fiscal Recovery			38,000	13,900				
Total	**588,770**	**1,286,126**	**1,338,014**	**1,661,850**	**1,332,054**	**1,328,232**	**1,389,173**	**1,372,601**
Biennial Change				1,124,968		(339,578)		(238,090)
Biennial % Change				60		(11)		(8)
Governor's Change from Base								101,488
Governor's % Change from Base								4
Expenditures by Category								
Operating Expenses	81	12,400	220	1,000	1,000	1,000	1,000	1,000
Grants, Aids and Subsidies	588,689	1,273,726	1,337,794	1,660,850	1,331,054	1,327,232	1,388,173	1,371,601
Total	**588,770**	**1,286,126**	**1,338,014**	**1,661,850**	**1,332,054**	**1,328,232**	**1,389,173**	**1,372,601**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		1,422		594				
Direct Appropriation	60,277	24,240	29,740	32,740	32,740	32,740	89,859	77,109
Transfers In	1,675	1,675	1,675	1,675	1,675	1,675	1,675	1,675
Transfers Out	1,675	1,675	1,675	1,675	1,675	1,675	1,675	1,675
Cancellations	134	2,546	236					
Balance Forward Out	1,422		594					
Expenditures	**58,721**	**23,116**	**28,910**	**33,334**	**32,740**	**32,740**	**89,859**	**77,109**
Biennial Change in Expenditures				(19,593)		3,236		104,724
Biennial % Change in Expenditures				(24)		5		168
Governor's Change from Base								101,488
Governor's % Change from Base								155
1251 - COVID-19 Minnesota								
Balance Forward In		386						
Direct Appropriation	386	13,300						
Cancellations		9,240						
Balance Forward Out	386							
Expenditures		**4,446**						
Biennial Change in Expenditures				(4,446)		0		0
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								
2000 - Restrict Misc Special Revenue								
Balance Forward In	47	47	49	47	47	47	47	47
Transfers In	140	140	140	140	140	140	140	140
Transfers Out			2					
Balance Forward Out	47	49	47	47	47	47	47	47
Expenditures	**140**	**138**	**140**	**140**	**140**	**140**	**140**	**140**
Biennial Change in Expenditures				2		0		0
Biennial % Change in Expenditures				1		0		0
Governor's Change from Base								0
Governor's % Change from Base								0

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
2001 - Other Misc Special Revenue								
Balance Forward In	0	182	7					
Receipts	365							
Expenditures	**365**	**182**	**7**					
Biennial Change in Expenditures				(540)		(7)		(7)
Biennial % Change in Expenditures				(99)				
Governor's Change from Base								0
Governor's % Change from Base								
3000 - Federal								
Balance Forward In	58	1,764	2,084	1	1	1	1	1
Receipts	525,922	1,181,176	1,246,914	1,614,476	1,299,174	1,295,352	1,299,174	1,295,352
Transfers Out	50							
Balance Forward Out	53	2,039	1	1	1	1	1	1
Expenditures	**525,876**	**1,180,901**	**1,248,996**	**1,614,476**	**1,299,174**	**1,295,352**	**1,299,174**	**1,295,352**
Biennial Change in Expenditures				1,156,695		(268,946)		(268,946)
Biennial % Change in Expenditures				68		(9)		(9)
Governor's Change from Base								0
Governor's % Change from Base								0
3010 - Coronavirus Relief								
Direct Appropriation	3,668	78,817	22,040					
Cancellations		1,474	79					
Expenditures	**3,668**	**77,344**	**21,961**					
Biennial Change in Expenditures				(59,051)		(21,961)		(21,961)
Biennial % Change in Expenditures				(73)				
Governor's Change from Base								0
Governor's % Change from Base								
3015 - ARP-State Fiscal Recovery								
Balance Forward In				1,000				
Direct Appropriation			39,000	12,900	0	0	0	0

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Balance Forward Out			1,000					
Expenditures			**38,000**	**13,900**				
Biennial Change in Expenditures				51,900		(51,900)		(51,900)
Biennial % Change in Expenditures						(100)		(100)
Governor's Change from Base								0
Governor's % Change from Base								

Program: Grant Programs
Activity: Refugee Services Grants

https://mn.gov/dhs/people-we-serve/children-and-families/services/refugee-assistance/

AT A GLANCE

- In state fiscal year (FY)19 an average of 1,549 people per month received employment and social services through Refugee Services grants.
- The average monthly cost per recipient in FY19 was $417 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 FY21 was $4.7 million. This represented 0.02% of the Department of Human Services overall budget.

PURPOSE AND CONTEXT

Refugees are individuals who fled 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 aid 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 assistance (Minnesota Family Investment Program) and health care programs available to state residents with 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 that are available to Minnesota residents 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*
Quantity	Percent of refugees receiving health screening within 90 days of arrival	97%	97%	Sept 2019 Sept 2020
Result	Job retention rate within 90 days	81%	76%	Sept 2019 Sept 2020
Quantity	Average hourly wage	$13.03	$14.75	Sept 2019 Sept 2020

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)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
2000 - Restrict Misc Special Revenue		815	900					
3000 - Federal	4,727	4,788	16,205	34,326	42,451	45,451	42,451	45,451
3010 - Coronavirus Relief		711						
Total	**4,727**	**6,314**	**17,105**	**34,326**	**42,451**	**45,451**	**42,451**	**45,451**
Biennial Change				40,390		36,471		36,471
Biennial % Change				366		71		71
Governor's Change from Base								0
Governor's % Change from Base								0
Expenditures by Category								
Operating Expenses	582	457	554	850	930	930	930	930
Grants, Aids and Subsidies	4,145	5,857	16,551	33,476	41,521	44,521	41,521	44,521
Total	**4,727**	**6,314**	**17,105**	**34,326**	**42,451**	**45,451**	**42,451**	**45,451**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
2000 - Restrict Misc Special Revenue								
Balance Forward In			76					
Receipts		185	824					
Transfers In		630						
Expenditures		**815**	**900**					
Biennial Change in Expenditures				85		(900)		(900)
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								
3000 - Federal								
Balance Forward In			0					
Receipts	4,727	4,788	16,205	34,326	42,451	45,451	42,451	45,451
Expenditures	**4,727**	**4,788**	**16,205**	**34,326**	**42,451**	**45,451**	**42,451**	**45,451**
Biennial Change in Expenditures				41,016		37,371		37,371
Biennial % Change in Expenditures				431		74		74
Governor's Change from Base								0
Governor's % Change from Base								0
3010 - Coronavirus Relief								
Transfers In		740						
Transfers Out		29						
Expenditures		**711**						
Biennial Change in Expenditures				(711)		0		0
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								

Program: Grants Program
Activity: Health Care Grants

AT A GLANCE

- There are currently 675 navigators and in person assisters available statewide to aid people in obtaining health care coverage.
- Navigators and in person assisters provided application assistance to over 26,668 individuals or families enrolled in public health care programs during FY 2021.
- All 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 2021 was $15.1 million. This represents 0.1 percent of the Department of Human Services overall budget.

PURPOSE AND 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 supplement 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. In 2021 and 2022, these funds supported legal assistance to 311 people who had or were likely to access Emergency Medical Assistance (EMA). 51 of these individuals became eligible for MA or MinnesotaCare because of changes in their immigration status.
- **Immunization Registry Grants.** Provides administrative funds to counties to support immunization registries.
- **Child and Teen Checkup Grants.** Provides funding to over 50 tribes and community health boards for outreach and education to children on Medical Assistance related to Child and Teen Checkup services.

- **Integrated Care for High Risk Pregnancies (ICHRP). Integrated Care for High Risk Pregnancies (ICHRP).** This program provides funding for community-led collaborative care models to improve birth outcome disparities in the MA program. ICHRP grants support community-led planning, systems development, and the integration of medical, chemical dependency, public health, social services, and child welfare coordination to address the psycho-social conditions that negatively influence maternal and birth outcomes. Current grantees include three community-based organizations in the Twin Cities metro area that promote the health of mothers, support for fathers and healthy development of African American babies. Five Tribal organizations received earlier ICHRP grants, but then transitioned to federal funding focused on addressing opioids among pregnant people and nursing parents. During this period they phased out of the state-funded program temporarily. The American Indian community is again receiving state ICHRP funding effective in state fiscal year 2022, represented by two community-based coalitions in the Bemidji and Twin Cities regions.
- **Minnesota Medicaid Promoting Interoperability Program (formerly the EHR Incentive Program).** Distributed federal funds to eligible providers and hospitals that purchased and shared information using certified electronic health records. The goal of this program was to improve the patient experience, promote public health and access to health care records, while reducing cost and provider burden. The program is in its final audit and close-out period, sun-setting completely in 2023. From the program's inception in 2011 through the end of incentive payments in 2021, MPIP distributed $252,832,642 in federally-funded incentive payments to 3,306 unique providers, clinics, and hospitals across the State of Minnesota.
- **Periodic Data Matching Grants.** Provides funds to counties to offset their costs in resolving discrepant information for MA and MinnesotaCare enrollees flagged as potentially ineligible through periodic data matching of available electronic data sources.

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.

Please note that the numbers below are affected by Federal Public Health Emergency (PHE) requirements to extend continuous coverage to many enrollees on MA and MinnesotaCare in order for the state to draw down enhanced federal funding in order to respond to COVID-19. Because continuous coverage has been extended and MA and MinnesotaCare caseloads are at a historic high, fewer enrollees have required assistance in applying for and enrolling in public health care coverage programs.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Enrollees receiving support from MNCAAs/In Person Assisters[1]	53,540	26,668	FY 2019 and FY 2021

1. Measure is the number of MNCAAs and In Person Assisters receiving incentive payments as reported by MNsure and DHS staff.

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)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	3,482	3,539	4,486	4,811	4,811	4,811	43,311	8,797
2360 - Health Care Access	1,674	667	2,672	3,465	3,465	3,465	8,401	3,465
3000 - Federal	15,604	11,461	18,568	22,186	25,063	28,529	25,063	28,529
3010 - Coronavirus Relief		3,229						
3015 - ARP-State Fiscal Recovery				370				
Total	**20,760**	**18,896**	**25,727**	**30,832**	**33,339**	**36,805**	**76,775**	**40,791**
Biennial Change				16,903		13,585		61,007
Biennial % Change				43		24		108
Governor's Change from Base								47,422
Governor's % Change from Base								68
Expenditures by Category								
Operating Expenses	1,541	1,205	1,065	5,621	5,620	5,620	5,620	5,620
Grants, Aids and Subsidies	19,219	17,692	24,662	25,211	27,719	31,185	71,155	35,171
Total	**20,760**	**18,896**	**25,727**	**30,832**	**33,339**	**36,805**	**76,775**	**40,791**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In	900	730						
Direct Appropriation	3,711	3,711	4,811	4,811	4,811	4,811	43,311	8,797
Cancellations	499	902	325					
Balance Forward Out	630							
Expenditures	**3,482**	**3,539**	**4,486**	**4,811**	**4,811**	**4,811**	**43,311**	**8,797**
Biennial Change in Expenditures				2,276		325		42,811
Biennial % Change in Expenditures				32		3		460
Governor's Change from Base								42,486
Governor's % Change from Base								442
2360 - Health Care Access								
Direct Appropriation	3,465	3,465	5,547	3,465	3,465	3,465	8,401	3,465
Cancellations	1,791	2,798	2,875					
Expenditures	**1,674**	**667**	**2,672**	**3,465**	**3,465**	**3,465**	**8,401**	**3,465**
Biennial Change in Expenditures				3,797		793		5,729
Biennial % Change in Expenditures				162		13		93
Governor's Change from Base								4,936
Governor's % Change from Base								71
3000 - Federal								
Balance Forward In	118	1	1					
Receipts	15,486	11,460	18,567	22,186	25,063	28,529	25,063	28,529
Expenditures	**15,604**	**11,461**	**18,568**	**22,186**	**25,063**	**28,529**	**25,063**	**28,529**
Biennial Change in Expenditures				13,689		12,838		12,838
Biennial % Change in Expenditures				51		32		32
Governor's Change from Base								0
Governor's % Change from Base								0
3010 - Coronavirus Relief								
Direct Appropriation		3,343						
Cancellations		113						
Expenditures		**3,229**						
Biennial Change in Expenditures				(3,229)		0		0

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								

3015 - ARP-State Fiscal Recovery

Direct Appropriation				370	0	0	0	0
Expenditures				**370**				
Biennial Change in Expenditures				370		(370)		(370)
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								

Program: Grant Programs
Activity: Other Long-Term Care Grants

AT A GLANCE

- This budget activity covers grants that serve multiple populations including people with disabilities, people with a mental illness and older adults.
- The Home and Community-Based Service (HCBS) Innovation Pool was established in FY17 to support increased innovation in HCBS programs. The appropriation for FY20 was $1,925,000 and FY21 was $1,925,000. The base appropriation is $1,925,000.
- The Home and Community-Based Service (HCBS) Innovation Pool funding supported 19 grant contracts in FY2020 and 20 grant contracts in FY21.
- Moving Home Minnesota (MHM), a Money Follows the Person (MFP) federal demonstration grant, was awarded $14,237,923 for CY21, and an additional $4,104,657 to support additional transitions to the community. Total CY21 award was amended to $18,342,580. The CY22 award was $22,011,096. MHM budgeted funds to support up to 453 community transitions across CY21-22.
- The (MFP) Capacity Building grant was awarded by the Centers for Medicare and Medicaid Systems (CMS) in CY21, as a supplement to the MFP grant. This $5,000,000 grant is being used to support four Tribal Nations' capacity building over a span of four years.
- All funds spending for the Other Long-Term Care grants activity for FY21 was $33.10 million. This represented 0.16 percent of the Department of Human Services overall budget.

PURPOSE AND 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, people with a mental illness, and seniors.

Currently, the following grants are included in Other Long-Term Care Grants, which will expand as more cross-population grants are developed.

The HCBS Innovation Pool grant incentivizes providers to innovate in achieving integrated competitive employment, living in the most integrated setting, and other outcomes. The Innovation pool began distributing funds in FY17.

The Money Follows the Person (MFP) federal demonstration grant supports the state's effort to rebalance their long-term services and supports system to ensure individuals have a choice of where they live and receive services. This program is called Moving Home Minnesota specifically for Minnesota. The Minnesota MFP demonstration also supports the MFP Tribal Initiative (TI), supporting the development of sustainable and culturally appropriate infrastructure and long-term services and supports for tribes and tribal members within Minnesota. The MFP Capacity Building grant is currently being utilized to suppor the MFP TI activities.

In addition, as part of the Money Follows the Person federal grant, States are eligible for an enhanced FFP that can be used for rebalancing projects. This is called the Moving Home Minnesota rebalancing fund. MHM has awarded nearly $12 million in funds to support innovation and projects in the areas of: housing; service quality; equity; self-advocacy and person-centered thinking; and administration and systems improvement.

In FY21 two one-time grants were added to this budget activity from the federal Coronavirus Relief Fund: HCBS retainer grants and public health grants.

In FY22, three additional grants have been added to this budget activity from the federal American Rescue Plan Act (ARPA), totaling $26.09 million in the FY22-23 biennium. New grant activities were technology grants for HCBS recipents, provider capacity grants, and HCBS workforce development grants.

SERVICES PROVIDED

- The Home and Community-Based Service (HCBS) Innovation Pool rewards providers, service recipients, and other entities for innovation in achieving outcomes that improve quality of life, including integrated, competitive employment and living in the most integrated setting in the community. The funds were distributed via a request for proposal (RFP) process. There are three ways that the money was distributed:
    - Large grants (up to $500,000). These grants incentivize innovation in HCBS services. Some grantees use pay for performance concepts and models that utilize outcome-based payments consisting of financial incentives based on the outcomes proposed, produced and achieved.
    - Small grants ($5,000 - $50,000). This is for grants of up to $50,000 per year for 1 to 3 years. A simplified RFP process solicits participation from diverse grantees, beyond typical responders. This could include individuals, small groups, sole proprietors, small businesses, etc.
    - Micro grants ($100 - $2,000). The micro grant program provides 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.
- The Money Follows the Person (MFP) Rebalancing Demonstration grant supports efforts to rebalance spending on long-term services and supports to ensure individuals have a choice of where they live and receive services. Individuals wishing to move into the community that have resided in an institutional setting for over 60 days are supported in locating and transitioning to community-based care. The transition and a year of services in the community are funded by the grant. The services provided under the MFP grant are eligible for an enhanced federal financial participation (FFP) of 25%. The enhanced FFP is deposited into a special revenue fund, and began funding rebalancing demonstration projects in FY19. The 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.
- Funds under the Money Follows the Person Tribal Initiative are similarly used to improve access to community-based long-term care services and supports (CB-LTSS) for American Indians and Alaska Natives who have been in an institutional setting for over 90 days. In addition, the Tribal Initiative may be used to advance the development of an infrastructure required to implement CB-LTSS for American Indians and Alaska Natives using a single, or a variety of applicable Medicaid authorities. Funding is intended to support the planning and development of:
    - An in-state Medicaid program CB-LTSS (as an alternative to institutional care) tailored for American Indians and Alaska Natives who are presently receiving services in an institution; and
    - A service delivery structure that includes a set of administrative functions delegated by the state Medicaid agency to Tribes or Tribal organizations, 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 Tribal Initiative 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.

- Retainer grants were for eligible providers to assist with the costs of business interruptions due to required COVID-19 closures and to help ensure service access following the pandemic. Grants amounts equaled 66% of the revenue providers received for eligible services in January 2020. Two hundred nine (209) providers received a grant, totaling $15.2 million in payments. Providers of the following services were eligible to receive these funds:
    - Adult day services provided under the BI, CADI, DD, EW waivers and AC program
    - Day training & habilitation provider under the DD waiver
    - Prevocational services provided under the BI and CADI waivers
    - Structured day services provided under the BI waiver
    - Employment exploration, development, and support services provided under the DD, CADI, CAC, and BI waiver
    - Early Intensive Developmental and Behavioral Intervention (EIDBI) services
- Public health grants - Eligible disability services providers used the funds to improve social distancing practices to reduce the risk of exposure to and transmission of COVID-19 to people with disabilities and staff who support them by:
    - Maintaining or increasing use of individualized day or employment services.
    - Reducing use of congregate and sheltered workshop settings.
    - Eighty-four (84) unique recipients received a grant, totaling $15.3 million in payments. For full details please see the legislative report Disability services provider COVID-19-related public health grants (https://www.lrl.mn.gov/docs/2021/mandated/210780.pdf).
- Technology for HCBS recipients grants ($2.5 million in the FY22-23 biennium) provides for one-time funding for technology to support people living in their own homes to enhance access to HCBS services and strengthen a person's ability to live independently.
- Provider capacity grants for Rural and Underserved Communities ($14 million in the FY22-23 biennium) provides temporary funding for small provider organizations serving rural or underserved communities.
- HCBS workforce development grants ($5.588 million in the FY22-23 biennium) to attract and retain direct care workers who provide home and community-based services for people with disabilities and older adults.

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 Employment First Dashboard (https://mn.gov/dhs/employment-first-dashboards) and Long-Term Service and Support Performance Dashboards (https://mn.gov/dhs/ltss-program-performance).

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Result	Percent of working age people on certain Medical Assistance programs earning $600 or more per month.	17.7%	15.8%	FY 2019 to FY 2021
Result	Percent of people with disabilities who receive home and community-based services at home.	56.7%	63.2%	FY 2017 to FY 2021
Result	Percent of older adults who receive home and community-based services at home.	62.4%	63.3%	FY 2017 to FY 2021

Performance Measures Notes:

1. Measure compares monthly earnings for people age 18-64 who receive services from one of the following Medical Assistance programs: Home and Community-Based Waiver Services, Mental Health Targeted Case Management, Adult Mental Health Rehabilitative Services, Assertive Community Treatment and Medical Assistance for Employed Persons with Disabilities (MA-EPD). Source: DHS Data Warehouse.
2. This measure compares people who receive disability waiver services in their own home rather than residential services. Source: DHS Data Warehouse.
3. This measure compares older adults receiving services in their own home rather than residential services. Source: DHS Data Warehouse.

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	1,893	1,643	1,925	30,181	19,013	1,925	45,266	24,925
2001 - Other Misc Special Revenue	450	950	1,685	2,912	2,932	2,952	2,932	2,952
3000 - Federal	785	1,166	1,108	2,978	3,574	4,288	3,574	4,288
3010 - Coronavirus Relief		30,560						
3015 - ARP-State Fiscal Recovery			49,900					
Total	**3,127**	**34,320**	**54,618**	**36,071**	**25,519**	**9,165**	**51,772**	**32,165**
Biennial Change				53,242		(56,005)		(6,752)
Biennial % Change				142		(62)		(7)
Governor's Change from Base								49,253
Governor's % Change from Base								142
Expenditures by Category								
Operating Expenses	97	22						
Grants, Aids and Subsidies	3,031	34,286	54,618	36,071	25,519	9,165	51,772	32,165
Other Financial Transaction		12						
Total	**3,127**	**34,320**	**54,618**	**36,071**	**25,519**	**9,165**	**51,772**	**32,165**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In				8,500				
Direct Appropriation	1,925	1,925	10,608	21,681	19,013	1,925	45,266	24,925
Cancellations	32	282	183					
Balance Forward Out			8,500					
Expenditures	**1,893**	**1,643**	**1,925**	**30,181**	**19,013**	**1,925**	**45,266**	**24,925**
Biennial Change in Expenditures				28,570		(11,168)		38,085
Biennial % Change in Expenditures				808		(35)		119
Governor's Change from Base								49,253
Governor's % Change from Base								235
2000 - Restrict Misc Special Revenue								
Balance Forward In	4,408							
Transfers Out	4,408							
2001 - Other Misc Special Revenue								
Balance Forward In		5,826	6,663	7,667	7,331	7,076	7,331	7,076
Transfers In	6,276	1,433	2,689	2,576	2,677	2,765	2,677	2,765
Balance Forward Out	5,826	6,309	7,667	7,331	7,076	6,889	7,076	6,889
Expenditures	**450**	**950**	**1,685**	**2,912**	**2,932**	**2,952**	**2,932**	**2,952**
Biennial Change in Expenditures				3,197		1,287		1,287
Biennial % Change in Expenditures				228		28		28
Governor's Change from Base								0
Governor's % Change from Base								0
3000 - Federal								
Receipts	785	1,166	1,108	2,978	3,574	4,288	3,574	4,288
Expenditures	**785**	**1,166**	**1,108**	**2,978**	**3,574**	**4,288**	**3,574**	**4,288**
Biennial Change in Expenditures				2,135		3,776		3,776
Biennial % Change in Expenditures				109		92		92
Governor's Change from Base								0
Governor's % Change from Base								0

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
3010 - Coronavirus Relief								
Balance Forward In			24					
Direct Appropriation		30,687						
Transfers In		4,945						
Transfers Out		4,945						
Cancellations		103	24					
Balance Forward Out		24						
Expenditures		**30,560**						
Biennial Change in Expenditures				(30,560)		0		0
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								
3015 - ARP-State Fiscal Recovery								
Direct Appropriation			49,900					
Expenditures			**49,900**					
Biennial Change in Expenditures				49,900		(49,900)		(49,900)
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								

Program: Grant Programs
Activity: Aging & Adult Services Grants

http://mn.gov/dhs/people-we-serve/seniors/

AT A GLANCE

- Provides congregate dining to 20,400 people and home delivered meals to 24,000 people annually.
- Funded by the Minnesota Board on Aging, AmeriCorps, Senior (formally Senior Corps) supports about 10,000 older volunteers per year who provide services through the Retired and Senior Volunteer Program (RSVP), Foster Grandparents, and Senior Companions
- Provided comprehensive assistance and individualized help to more than 134,000 individualsthrough over 280,000 calls in CY21 through the Senior LinkAge Line®.
- Educated over 8,500 community members about Alzheimer's or other dementias, and provided services, supports and resources to nearly 2,500 family, friends, and neighbor caregivers and almost 2,500 persons suspected or diagnosed with Alzheimer's or other dementias through the Dementia grant program in CY21.
- Funded home and community-based service options through the Community Service/Services Development (Live Well at Home) grant program in CY21.
- All funds spending for the Aging & Adult Services Grants activity was $68.14 million in FY2021. This represented 0.34 percent of the Department of Human Services overall budget.

PURPOSE AND 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 provides various services to older adults including 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 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, fall 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 2021, over 22,000 consumers have been contacted for discharge support. Of those 22,000, direct assistance was provided to over 6,647 older adults at their request to return home and an additional 3,747 in 2018 through 2021 received education or telephone assurance for 3 to 5 years. During COVID, without the ability to meet in person, tele-visits were adopted and more follow up calls were provided if requested.
- 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 provides grants to nonprofit providers who deliver 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.
- Funding to assisted living providers who serve public pay participants to support quality improvement initiatives, through the customized living quality improvement grants.
- In FY22, additional Age-Friendly Minnesota and Quality Improvement Customized Living grant projects funded through the federal American Rescue Plan Act (ARPA) were approved, totalling $2.45 million in the FY22-23 biennium.

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 proportion of older adults served by community-based rather than institution-based services. The percent of older adults served in the community has improved over the past four 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	Percent of older adults served by home and community-based services[1]	72.8%	79.1%	FY 2017 to FY 2021
Quality	Percent of consumers who would recommend the Senior LinkAge Line® to others[2]	94%	90%	2017 to 2019
Quantity	Number of older adults who receive meals through the Congregate and Home Delivered Meal Programs.	45,773	44,494	2020 to 2022

More information is available on the Long-Term Service and Support Performance Dashboard (https://mn.gov/dhs/ltss-program-performance)

Results Notes:

1. This measure shows the percentage of older adults receiving publicly-funded long-term services and supports who receive home and community-based services through the Elderly Waiver, Alternative Care, or home care programs instead of nursing home services. (Source:DHS Data Warehouse)
2. Due to COVID, the in person and paper quality form was discontinued in 2020. Since the governor's emergency has been lifted, it will be reinstated in October, 2022 and has been converted from paper to an after call survey which should increase the response rate and provide feedback at the regional and agent level. (Source: Consumer Surveys, Web Referral database)
3. This is a new measure that reflects the expansion of the Return to Community initiative. (Source: Return to Community Database)

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)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	31,879	30,162	31,408	39,445	34,445	32,995	43,605	44,465
2001 - Other Misc Special Revenue	161	26						
3000 - Federal	39,672	41,533	48,556	45,152	36,475	35,522	36,475	35,522
3010 - Coronavirus Relief		587						
Total	**71,712**	**72,307**	**79,965**	**84,597**	**70,920**	**68,517**	**80,080**	**79,987**
Biennial Change				20,543		(25,125)		(4,495)
Biennial % Change				14		(15)		(3)
Governor's Change from Base								20,630
Governor's % Change from Base								15
Expenditures by Category								
Operating Expenses	1,981	2,543	3,426	1,819	1,819	1,819	1,819	1,819
Grants, Aids and Subsidies	69,730	69,764	76,539	82,778	69,101	66,698	78,261	78,168
Total	**71,712**	**72,307**	**79,965**	**84,597**	**70,920**	**68,517**	**80,080**	**79,987**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Direct Appropriation	32,311	32,495	32,995	39,445	34,445	32,995	43,605	44,465
Cancellations	432	2,333	1,587					
Expenditures	**31,879**	**30,162**	**31,408**	**39,445**	**34,445**	**32,995**	**43,605**	**44,465**
Biennial Change in Expenditures				8,813		(3,413)		17,217
Biennial % Change in Expenditures				14		(5)		24
Governor's Change from Base								20,630
Governor's % Change from Base								31
2001 - Other Misc Special Revenue								
Balance Forward In	49	0						
Receipts	112	26						
Balance Forward Out	0	0						
Expenditures	**161**	**26**						
Biennial Change in Expenditures				(187)		0		0
Biennial % Change in Expenditures				(100)				
Governor's Change from Base								0
Governor's % Change from Base								
3000 - Federal								
Balance Forward In	8	8	8	8	8	8	8	8
Receipts	39,665	41,525	48,556	45,152	36,475	35,522	36,475	35,522
Balance Forward Out			8	8	8	8	8	8
Expenditures	**39,672**	**41,533**	**48,556**	**45,152**	**36,475**	**35,522**	**36,475**	**35,522**
Biennial Change in Expenditures				12,503		(21,711)		(21,711)
Biennial % Change in Expenditures				15		(23)		(23)
Governor's Change from Base								0
Governor's % Change from Base								0
3010 - Coronavirus Relief								
Balance Forward In			109					
Direct Appropriation		8,145						
Cancellations		7,450	109					
Balance Forward Out		109						

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures		**587**						
Biennial Change in Expenditures				(587)		0		0
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								

Program: Grant Programs
Activity: Deaf & Hard of Hearing Grants

https://mn.gov/dhs/people-we-serve/adults/services/deaf-hard-of-hearing/programs-services/

AT A GLANCE

- Deaf and Hard of Hearing grants served 612 individuals who are deaf, deafblind, hard of hearing and speaking deaf in state FY21.
- 263 adults and children with hearing loss received culturally affirmative mental health services that included access to American Sign Language (ASL) in FY21.
- 164 adults and children who are deafblind received services to establish and maintain their independence, develop knowledge and skills, and participate fully in their families and/or communities in FY21.
- 88 families who have a young child with hearing loss received support for the development of their child's communication and other life skills from adult mentors who also have hearing loss in FY21.
- Consumers with hearing loss were provided with accessible local news through 2,025.5 hours of real time captioning services for live TV news programming in Minnesota.
- 220 providers (sign language interpreters) participated in statewide training and mentorship activities that enabled them to better meet the evolving communication needs of the deaf, deafblind, and hard of hearing community.
- All funds spending for the Deaf and Hard of Hearing Grants activity for FY21 was $2.7 million. This represented 0.01% of the Department of Human Services overall budget.

PURPOSE AND CONTEXT

National research estimates 20% of the population has some degree of hearing loss. In Minnesota, this means approximately 1.15 million people are likely to have some degree of hearing loss (out of the total population of 5,742,036 for FY21 as estimated by the state demographer). Of those, an estimated 11% are deaf and as many as 1,640 individuals are deafblind. The number of Minnesotans with hearing loss is projected to increase significantly over the next 40 years due to factors like aging and noise exposure.

One-third of people between ages 65-74 have hearing loss and nearly half of those over age 75 have hearing loss. According to the Minnesota Department of Health, permanent childhood hearing loss affects between 200 and 400 infants born in Minnesota each year.

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 Services partners with statewide community providers, mental health professionals, local television stations and the Department of Commerce to provide services.

Grants are primarily funded by the state general fund. In addition, the Telecommunications Access Minnesota (TAM) funds collected by the Department of Commerce provide the grants for real-time television captioning of local news programs.

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 everyday activities and core services such as medical care, mental health services, human services, the judicial system, and self-help; this activity includes two programs to increase the number of interpreters in Greater Minnesota available to provide community interpreting services and pays travel costs to bring interpreters to areas where there are no local interpreters.
- 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.

RESULTS

Due to the unique and tailored nature of Deaf and Hard of Hearing's grants, measurements vary for each grant and population served. People served in DHHSD's grant-funded programs have the opportunity to fill out surveys which measure satisfaction with the quality and timeliness of services. Results represent responses from the *consumers*.

- Across all grants on average consumers reported a high level of satisfaction with the quality of services.
- Across the 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%.
- In a variety of programs that support families with a child who is deaf, deafblind, or hard of hearing, at least 90% of parents reported noticeable improvement in their child's progress in communication, social development and community integration as a result of the services they receive.
- FY21 Data reflects the challenges that the consumers and clients experienced while seeking and receiving services through DHHS grant-funded programs in light of the COVID-19 pandemic starting in March 2020 and throughout the FY21.

Type of Measure	*Name of Measure*	*Previous* 2019-2020	*Current 2020-2021*
Quality	1. Percent of consumers in DHHS grant-funded programs who are satisfied with quality of services they received.	82%	82%
Quality	2. Percent of consumers in DHHS grant-funded programs who are satisfied with timeliness of the services they received.	89%	79%
Quality	3. Percent of clients in DHHS grant-funded mental health programs who completed or are making good progress on their treatment plan goals.	91%	82%
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 deaf, hard of hearing, or deafblind.	94%	90%

Performance Notes:

- Data source: Consumer satisfaction surveys and grantee reports.

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.

Deaf & Hard of Hearing Grants

Activity Expenditure Overview

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	2,784	2,850	2,862	2,886	2,886	2,886	2,886	2,886
2001 - Other Misc Special Revenue	264	273	149	137				
2403 - Gift				13	13	13	13	13
3000 - Federal	75	75	75	75	75	75	75	75
Total	**3,123**	**3,198**	**3,085**	**3,111**	**2,974**	**2,974**	**2,974**	**2,974**
Biennial Change				(125)		(248)		(248)
Biennial % Change				(2)		(4)		(4)
Governor's Change from Base								0
Governor's % Change from Base								0
Expenditures by Category								
Operating Expenses		32		13	13	13	13	13
Grants, Aids and Subsidies	3,123	3,166	3,085	3,098	2,961	2,961	2,961	2,961
Total	**3,123**	**3,198**	**3,085**	**3,111**	**2,974**	**2,974**	**2,974**	**2,974**

Deaf & Hard of Hearing Grants

Activity Financing by Fund

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Direct Appropriation	2,886	2,886	2,886	2,886	2,886	2,886	2,886	2,886
Cancellations	102	36	24					
Expenditures	**2,784**	**2,850**	**2,862**	**2,886**	**2,886**	**2,886**	**2,886**	**2,886**
Biennial Change in Expenditures				113		24		24
Biennial % Change in Expenditures				2		0		0
Governor's Change from Base								0
Governor's % Change from Base								0
2001 - Other Misc Special Revenue								
Balance Forward In		2	6					
Receipts	295	306	180	137				
Transfers In		1	14					
Transfers Out	30	29	51					
Balance Forward Out	2	6						
Expenditures	**264**	**273**	**149**	**137**				
Biennial Change in Expenditures				(252)		(286)		(286)
Biennial % Change in Expenditures				(47)		(100)		(100)
Governor's Change from Base								0
Governor's % Change from Base								
2403 - Gift								
Receipts				13	13	13	13	13
Expenditures				**13**	**13**	**13**	**13**	**13**
Biennial Change in Expenditures				13		13		13
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								0
3000 - Federal								
Receipts	75	75	75	75	75	75	75	75
Expenditures	**75**	**75**	**75**	**75**	**75**	**75**	**75**	**75**
Biennial Change in Expenditures				0		0		0
Biennial % Change in Expenditures				0		0		0

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Governor's Change from Base								0
Governor's % Change from Base								0

https://mn.gov/dhs/people-we-serve/people-with-disabilities/services/

AT A GLANCE

- The Family Support Grant served 1,636[i] people in FY21.
- The Consumer Support Grant supported an average of 2,693 people a month in FY21.
- Semi-independent living services served 1,522[ii] people in FY21.
- HIV/AIDS programs helped 4,086[iii] people living with HIV/AIDS.
- The Disability Hub MN, in FY21 served 26,264 people, had 86,695 contacts and 67 educational events. In FY22 the Hub served 28,447 people, had 71,108 contacts and 30 educational events.[iv]
- In FY22 new grants have been added to this budget activity funded through the federal American Rescue Plan Act (ARPA), totaling $18.546 million in the FY22-23 biennium.
- All funds spending for the Disabilities Grants activity for FY21 was $79.20 million. This represented 0.39 percent of the Department of Human Services overall budget.

PURPOSE AND CONTEXT

The US Census Bureau estimates that nearly 600,000 or over ten 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 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 with our Programs and Services page:

- Family Support Grant (https:/mn.gov/dhs/people-we-serve/people-with-disabilities/services/home-community/programs-and-services/fsg.jsp)
- Consumer Support Grant Program (https://mn.gov/dhs/people-we-serve/people-with-disabilities/services/home-community/programs-and-services/csg.jsp)
- Semi-independent Living Services (https://mn.gov/dhs/people-we-serve/people-with-disabilities/services/home-community/programs-and-services/sils.jsp)
- HIV/AIDS programs (https://mn.gov/dhs/people-we-serve/seniors/health-care/hiv-aids/programs-services/)
- Disability Hub MN (https://disabilityhubmn.org/)

SERVICES PROVIDED

Disabilities Grant programs include:

- The Family Support Grant (FSG) provides cash to families to offset the higher-than-average cost of raising a child with a disability.
- The Consumer Support Grant (CSG) is an alternative to home care paid through the Medical Assistance, which helps people purchase home care, adaptive aids, home modifications, respite care, and other help with the tasks of daily living. This program will sunset when Community First Services and Supports (CFSS) replaces the services provided by CSG.

- Semi-Independent Living Services (SILS) grants help adults with developmental disabilities, who do not require an institutional level of care, live in the community. The funding is used for 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 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.
- The Disability Hub MN, provides one-to-one assistance to make it easier for people with disabilities to understand their options, find solutions, and engage in possibilities.
- Technology grants for alternatives to corporate foster care, funds the multidisciplinary team approach to person centered assistive technology (AT) consultation and technical assistance to help individuals with disabilities live more independently. People who want to stay home or move home direct the outcome; the grantee assists with the technology resources.
- Pre-admission Screening and Resident Review activities determine a person's need for nursing facility (NF) level of care for Medical Assistance (MA). Lead agencies costs related to this activity are reimbursed through these grants.
- Intractable epilepsy grants provide independent living services training to adults with intractable epilepsy and information, assistance, and referral to guardians of and families with children under the age of 18 who have severe or intractable epilepsy.
- Local planning grants assist counties and tribes in development of community alternatives to corporate foster care settings. This funding is used to implement specific county plans to address the needs of people with disabilities in their communities.
- Day Training and Habilitation (DT&H) grants are allocated to counties. Counties pay for DT&H costs for some residents. This funding is allocated to counties to help offset costs for legislative rate increases to day training and habilitation facilities, and Grant funding also supports providers who are projected to experience a significant funding gap at the completion of banding. This provision includes provider eligibility standards. Providers receiving grants are required to develop sustainability plans in partnership with DHS. DHS is required to provide technical assistance and financial management advice to grant recipients.
- Regional Quality Council grants fund four regional quality councils. The 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.
- Institutional Settings and Intellectual and Developmental Disability grants fund a disability advocacy organization to maintain and promote self-advocacy services and supports for persons with intellectual and developmental disabilities throughout the state.
- Innovation Grants for Families provide funding for grants to connect families through innovation grants, life planning tools and other resources as they support a family member with disabilities.
- Region Person Centered Cohort Grant is allocated to regional cohorts for training, coaching, and mentoring for Person-Centered Planning and collaborative safety practices.
- SEIU Grant Funding – Appropriates funding to pay stipends to PCA workers for taking additional training and for new worker orientation.
- Electronic Visit Verification Grant Funding (EVV) assists providers who choose to use their own electronic visit verification system. Providers of these services must comply with electronic visit verification standards, on a date established by the commissioner, after the state-selected system is in production. This is a two year grant program.

- Federally-funded traumatic brain injury grants will continue to expand on work done in the first grant cycle, with partnerships with the MN Department of Health, MN Brain Injury Alliance, and will expand into work with the DHS Housing Division to support housing and homeless service providers who work with people with brain injury – focusing on training/education and screening opportunities to get people connected to services.

ARPA funded grants in the FY22-23 biennium include:

- Parent-to-Parent Program for Families with Children with Disabilities provides individual support and assistance to 200 unique families across MN and supports, information, and training services through 1,342 family encounters.
- Self Advocacy Grants for People with Developmental Disabilities provides funding to establish a statewide advocacy network for people with intellectual and developmental disabilities
- Minnesota Inclusion Grant provides funds for self-advocacy groups of people with intellectual and developmental disabilities to develop and organize projects to increase inclusion and access to inclusive services, improve community integration outcomes, and educate decision makers and the public.
- Inclusive Child Care Access for Children with Disabilities to establish grants that will improve access, staff capacity, staff training and development and child care facilities for children with disabilities in child care settings.
- Provider reinvention grant program to promote independence and increase opportunities for people with disabilities to earn competitive wages. Support through this grant program includes a state appointed technical assistance firm, grants to help providers end their use of subminimum wages, and grants to expand the capacity of providers supporting competitive employment.
- MCIL HCBS Access Grants support people with disabilities to live in their own homes and communities by providing accessibility modifications that cannot be purchased through Medicaid due to the participant's eligibility.
  Transition to Community Initiative grants add corporate foster care and customized living to the list of eligible settings for persons accessing the Whatever it Takes Grants.

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 (https://hab.hrsa.gov/sites/default/files/hab/About/RyanWhite/legislationtitlexxvi.pdf) 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.

More information is also available on the DHS dashboard (http://dashboard.dhs.state.mn.us/).

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.	56.7%	63.2%	FY 2017 to FY 2021
Quality	2. Percent of consumers who would recommend the Disability Hub MN to others.	98%	98%	2019 to 2021
Quantity	3. Annual number of people served through the Technology for Home Services grant.	372	375	FY2019 to FY2021

1. This measure compares people who receive disability waiver services in their own home rather than residential services. More information is also available at https://mn.gov/dhs/ltss-program-performance. Source: DHS Data Warehouse.
2. This measure continues to show over 90% satisfaction with the Disability Hub services. Source: Disability Hub MN Customer Satisfaction Surveys.
3. This measure represents the unduplicated annual number of people served through the Technology for Home Services grant, which provides assistive technology for people in their own homes. Source: Technology for Home report. Source: DHS Data Warehouse.

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.

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[i] The total FY21 spending and divide it by the average grant amount ($2,000). Grants may not exceed $3,113.99 per calendar year for each eligible child.
[ii] Based on assumption of 2% recipient growth over FY 2018 estimation.
[iii] These numbers are from CAREWare, the client level database for Ryan White Services.
[iv] Information is from the Disability Hub Call Center report

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	54,150	57,729	63,911	74,465	61,562	23,250	142,271	35,550
2000 - Restrict Misc Special Revenue	13,439	15,792	16,585	10,413	8,832	8,832	8,832	8,832
2001 - Other Misc Special Revenue	131	228	285	55				
3000 - Federal	12,734	11,513	8,302	11,544	11,488	11,479	11,488	11,479
Total	**80,454**	**85,261**	**89,083**	**96,477**	**81,882**	**43,561**	**162,591**	**55,861**
Biennial Change				19,845		(60,117)		32,892
Biennial % Change				12		(32)		18
Governor's Change from Base								93,009
Governor's % Change from Base								74
Expenditures by Category								
Operating Expenses	5,421	4,018	4,962	2,739	2,684	2,684	2,684	2,684
Grants, Aids and Subsidies	75,033	81,243	84,121	93,738	79,198	40,877	159,907	53,177
Total	**80,454**	**85,261**	**89,083**	**96,477**	**81,882**	**43,561**	**162,591**	**55,861**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In				2,340				
Direct Appropriation	22,431	23,144	31,398	31,010	29,260	22,260	109,969	34,560
Transfers In	35,399	39,637	41,477	41,115	32,302	990	32,302	990
Cancellations	3,680	5,052	6,623					
Balance Forward Out			2,340					
Expenditures	**54,150**	**57,729**	**63,911**	**74,465**	**61,562**	**23,250**	**142,271**	**35,550**
Biennial Change in Expenditures				26,498		(53,564)		39,445
Biennial % Change in Expenditures				24		(39)		29
Governor's Change from Base								93,009
Governor's % Change from Base								110
2000 - Restrict Misc Special Revenue								
Balance Forward In	17,289	19,513	19,296	9,046	5,109	2,753	5,109	2,753
Receipts	13,134	13,353	9,503	9,132	9,132	9,132	9,132	9,132
Transfers Out	350	2,586	3,168	2,656	2,656	2,656	2,656	2,656
Balance Forward Out	16,634	14,488	9,046	5,109	2,753	397	2,753	397
Expenditures	**13,439**	**15,792**	**16,585**	**10,413**	**8,832**	**8,832**	**8,832**	**8,832**
Biennial Change in Expenditures				(2,233)		(9,334)		(9,334)
Biennial % Change in Expenditures				(8)		(35)		(35)
Governor's Change from Base								0
Governor's % Change from Base								0
2001 - Other Misc Special Revenue								
Balance Forward In	171	107						
Receipts		121	285	55				
Balance Forward Out	39							
Expenditures	**131**	**228**	**285**	**55**				
Biennial Change in Expenditures				(19)		(340)		(340)
Biennial % Change in Expenditures				(5)		(100)		(100)
Governor's Change from Base								0
Governor's % Change from Base								
3000 - Federal								

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Balance Forward In	144	0						
Receipts	12,591	11,512	8,302	11,544	11,488	11,479	11,488	11,479
Expenditures	**12,734**	**11,513**	**8,302**	**11,544**	**11,488**	**11,479**	**11,488**	**11,479**
Biennial Change in Expenditures				(4,401)		3,121		3,121
Biennial % Change in Expenditures				(18)		16		16
Governor's Change from Base								0
Governor's % Change from Base								0

Program: Grant Programs
Activity: Housing & Support Services Grants

https://mn.gov/dhs/partners-and-providers/program-overviews/housing-and-homelessness

AT A GLANCE

- The Housing and Support Services Division oversees five grant programs to support housing-related activity statewide.
- Services provided include case management, outreach and education, online housing search tools, and housing program administration.
- In the FY21, grant spending of over $11.29 million supported Minnesotans with disabilities with limited incomes to live with dignity, stability, respect and choice. This represents .055 percent of the Department of Human Services overall budget.

PURPOSE AND CONTEXT

The Housing and Support Services Division manages five grant programs to support housing for low-income Minnesotans with disabilities. These programs, which amount to nearly $20.5 million over the biennium, support people across the housing spectrum. This funding is an integral part in the Division's commitment to supporting systems that integrate housing, services, and income supports to enable people to live in the community of their choice.

SERVICES PROVIDED

- The Long-Term Homelessness Supportive Services grant supports multi-county and tribal collaboratives to assist individuals and families with long histories of homelessness to find and keep permanent housing. Grants fund case management, outreach, and direct assistance that allow individuals and families to find and stay in their housing.
- The Community Living Infrastructure grant, which began in 2018, integrates housing as a basic component of county and tribal human service agency work. Funds are available to 53 counties and three tribes across the state. Grant funding can be used in one or more of these areas: 1) outreach activities to individuals who are homeless or in institutions or other facility stays; 2) housing resource specialists who can provide information to individuals, family members, providers, advocates, etc. about housing resources they may be eligible for, as well as information about housing opportunities in their area; and 3) administration and monitoring of the Housing Support program by counties or tribes.
- The Real Time Housing Website grant funds the design, development and maintenance of a fully accessible and usable website to track availability of housing openings in real-time for people with disabilities across the state of Minnesota. It will help connect individuals, advocates, and family members to housing options and information about community living resources available. The website, named HB101 Places, has been built and is currently in its first phase of roll-out.
- The Housing Benefit 101 grant pays for the development and maintenance of the Housing Benefits 101 website which helps people with disabilities understand housing-related resources available to them according to their situation and needs. The website has information on housing programs that can make housing more affordable along with information on different types of housing options and services that can improve quality of life. HB101 has a Vault feature in which persons can securely store their personal information related to housing and utilize a personalized housing planning tool in their search for housing in the community of their choice.

- The Housing Access Services grant supports individuals with disabilities to find and access housing in the community. Since the fall of 2009, more than 2,500 people have used Housing Access Services to move from licensed or unlicensed settings to homes of their own.
- In addition to ongoing grants, COVID-19 Minnesota Fund dollars were appropriated to supplement the Community Living Infrastructure grant in FY22 and FY23 to provide outreach to engage people facing homelessness or living in segregated settings, screening for basic needs and assistance with referral to community living resources; build capacity to assist people and provide technical assistance and consultation on housing and related support services resources for persons with both disabilities and low income; to streamline administration or monitoring of the Housing Support Program; and to provide direct assistance to individuals to access and maintain housing in community settings.

RESULTS

Long-Term Homeless Supportive Services grant

Type of Measure	***Name of Measure***	***Number***	***Dates***
Quantity	Number of people and households served annually by the Long-Term Homeless Supportive Services Fund Grant	3,321 people, 1,943 households	FY2021

Type of Measure	***Name of Measure***	***Greater MN***	***Twin Cities***
Quantity	Regional breakdown of people served by the Long-Term Homeless Supportive Services Fund Grant Program	60%	40%

Community Living Infrastructure Grant

Type of Measure	***Name of Measure***	***Current***	***Dates***
Quantity	Estimated number of people served by Community Living Infrastructure outreach and housing resource specialists.	6,000 people	FY2021

Legal authority for Housing and Support Services Grants:
M.S. sections 256I.09 (https://www.revisor.mn.gov/statutes/cite/256I.09);
256K.26 (https://www.revisor.mn.gov/statutes/?id=256k.26);
256B.0658 (https://www.revisor.mn.gov/statutes/cite/256B.0658);
256I.04 (https://www.revisor.mn.gov/statutes/cite/256I.04)

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	9,264	10,364	18,622	19,364	18,364	10,364	19,464	11,464
1251 - COVID-19 Minnesota	114	1,171						
3000 - Federal		360	693					
3010 - Coronavirus Relief		336	30					
Total	**9,378**	**12,231**	**19,345**	**19,364**	**18,364**	**10,364**	**19,464**	**11,464**
Biennial Change				17,100		(9,981)		(7,781)
Biennial % Change				79		(26)		(20)
Governor's Change from Base								2,200
Governor's % Change from Base								8
Expenditures by Category								
Operating Expenses	211	16						
Grants, Aids and Subsidies	9,167	12,215	19,345	19,364	18,364	10,364	19,464	11,464
Total	**9,378**	**12,231**	**19,345**	**19,364**	**18,364**	**10,364**	**19,464**	**11,464**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Direct Appropriation	10,764	11,864	19,364	19,364	18,364	10,364	19,464	11,464
Cancellations	1,500	1,500	742					
Expenditures	**9,264**	**10,364**	**18,622**	**19,364**	**18,364**	**10,364**	**19,464**	**11,464**
Biennial Change in Expenditures				18,358		(9,258)		(7,058)
Biennial % Change in Expenditures				94		(24)		(19)
Governor's Change from Base								2,200
Governor's % Change from Base								8
1251 - COVID-19 Minnesota								
Balance Forward In		1,509						
Direct Appropriation	1,612							
Cancellations		338						
Balance Forward Out	1,499							
Expenditures	**114**	**1,171**						
Biennial Change in Expenditures				(1,285)		0		0
Biennial % Change in Expenditures				(100)				
Governor's Change from Base								0
Governor's % Change from Base								
3000 - Federal								
Receipts		360	693					
Expenditures		**360**	**693**					
Biennial Change in Expenditures				334		(693)		(693)
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								
3010 - Coronavirus Relief								
Balance Forward In			341					
Direct Appropriation		775						
Cancellations		360	311					
Balance Forward Out		79						
Expenditures		**336**	**30**					

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Biennial Change in Expenditures				(306)		(30)		(30)
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								

Program: Grant Program
Activity: Adult Mental Health Grants

https://mn.gov/dhs/people-we-serve/adults/health-care/mental-health/index.jsp

AT A GLANCE

- Approximately 223,760 adults in Minnesota have a serious mental illness.
- Provided Assertive Community Treatment to 2,087 people in CY21.
- Provided Crisis Housing Assistance to prevent homelessness of 275 people in facility-based treatment in CY21.
- Provided Housing with Support services to assist 2,761 persons with serious mental illness in accessing and retaining permanent supportive housing by the end of CY21.
- Provided Mobile Crisis Response Services to 10,518 people in response to crisis episodes in CY21. All funds spending for the Adult Mental Health Grants activity for FY21 was $80.3 million. This represented 0.395 percent of the Department of Human Services overall budget.

PURPOSE AND CONTEXT

The Adult Mental Health Grants support services for adults with mental illness and are administered by the Behavioral Health Division of the Behavioral Health, Housing and Deaf and Hard-of-Hearing Administration (BHDH) , using both federal and state funds. These funds, combined with county dollars, are used to identify and meet 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.

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 distributed in a number of ways. Some are allocated to to counties and tribes in the form of flexible block grants that can be used to fund a number of services. Other grants are awarded competitively to counties, tribes, 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 is designed to reduce the time that individuals remain at the Anoka Metro Regional Treatment Center (AMRTC) or the Forensic Mental Health Program (FMHP) located in St. Peter (formerly known as the Minnesota Security Hospital MSH) once they no longer need hospital level of care. This program funds transitional services, referred to as the Whatever It Takes (WIT) program, which is designed to work with the individual and their treatment teams in addressing unique discharge barriers faced by some individuals. The initiative promotes recovery and allows individuals to move to integrated settings of their choice as outlined in the Minnesota Olmstead Plan, which then opens beds at AMRTC and MSH for other individuals who need them.

Adult Mental Health Initiatives (AMHI). This state grant provides both AMHI and Community Support Program (CSP) funding to 19 single- and multi-county initiatives to support the community-based mental health service system for adults with Serious and Persistent Mental Illness (SPMI) who are under- or uninsured. Each region ranges in size from single large counties in the metro, to the White Earth Nation, to regions encompassing up to 18 counties in greater Minnesota. Services that can be provided using these funds include: prevention and outreach, diagnostic assessments and testing, transportation, peer support, residential crisis stabilization, supported employment/individualized placement and support services, ACT, housing subsidies, Adult Rehabilitative Mental Health Services (ARMHS), outpatient psychotherapy, outpatient medication management, day treatment, partial hospitalization, IRTS, and targeted case management. CSP funds are given directly to counties to implement CSP services in their communities. Similar to the AMHI funds, some counties choose to pool their CSP funds together and partner on service delivery.

Project for Assistance in Transition from Homelessness (PATH) - PATH is a federal program supplemented with state matching funds to provide 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 and provide them with services to meet basic needs, resources, and housing.

Crisis Housing – This program provides direct payments for rent, mortgage, and utility costs, to assist persons in 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 linked with supportive 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 experiencing a severe mental health problem that requires immediate assistance in their home, place of employment, or in a hospital emergency department. 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 targeted cultural and ethnic minority communities in Minnesota.

Mental Health Innovations – These grant funds are dedicated to finding innovative approaches for improving access to and the quality of community-based, outpatient mental health services. Programs are focused on helping people with mental illness receive effective and culturally specific services in their community.

RESULTS

Transitions to Community – FY21

- 150 unduplicated individuals received support through the Transition to Community program.
- Of the 150 individuals served, 81 individuals were discharged: 69 from AMRTC and 12 from MSH.
- Technical assistance was provided by DHS staff to navigate discharge options for an additional 11 individuals.

Adult Rehabilitative Mental Health Services (ARMHS), and Crisis Response

Information below is the most current available

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Number of Adults with Serious Mental Illness who received **Adult Rehabilitative Mental Health Services** (ARMHS)	21,109	20,175	CY 2018 to CY 2020
Quantity	Number of episodes for which **Mental Health Crisis Services** were provided	13,317	12,300	CY 2018 to CY 2020
Result	Percent of people needing hospitalization after receiving **crisis service interventions**	11%	8%	CY 2019 to CY 2021

Performance Measure Notes:

- Source: DHS Data Warehouse

MS § 256E.12, 245.4661, and 245.70 provide the authority for the grants in this budget activity.

Adult Mental Health Grants

Activity Expenditure Overview

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	81,658	69,625	80,990	119,774	99,795	101,657	129,537	143,175
2000 - Restrict Misc Special Revenue	994	1,337	1,313	1,088	1,088	1,088	1,088	1,088
2005 - Opiate Epidemic Response		1,825	1,862	2,000	2,000		2,000	
3000 - Federal	7,556	9,824	10,462	35,025	30,148	24,744	30,148	24,744
3010 - Coronavirus Relief		768	23					
Total	**90,209**	**83,378**	**94,649**	**157,887**	**133,031**	**127,489**	**162,773**	**169,007**
Biennial Change				78,950		7,984		79,244
Biennial % Change				45		3		31
Governor's Change from Base								71,260
Governor's % Change from Base								27
Expenditures by Category								
Operating Expenses	1,295	1,689	1,635	1,900	226	226	226	226
Grants, Aids and Subsidies	88,913	81,689	93,014	155,987	132,805	127,263	162,547	168,781
Total	**90,209**	**83,378**	**94,649**	**157,887**	**133,031**	**127,489**	**162,773**	**169,007**

Adult Mental Health Grants

Activity Financing by Fund

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		20		13,775				
Direct Appropriation	84,302	79,877	98,772	105,999	99,795	101,657	129,537	143,175
Cancellations	2,644	10,272	4,007					
Balance Forward Out			13,775					
Expenditures	**81,658**	**69,625**	**80,990**	**119,774**	**99,795**	**101,657**	**129,537**	**143,175**
Biennial Change in Expenditures				49,481		688		71,948
Biennial % Change in Expenditures				33		0		36
Governor's Change from Base								71,260
Governor's % Change from Base								35
2000 - Restrict Misc Special Revenue								
Balance Forward In	372	380	1,506	1,212	1,212	1,212	1,212	1,212
Receipts	1,000	1,615	1,019	1,088	1,088	1,088	1,088	1,088
Balance Forward Out	378	658	1,212	1,212	1,212	1,212	1,212	1,212
Expenditures	**994**	**1,337**	**1,313**	**1,088**	**1,088**	**1,088**	**1,088**	**1,088**
Biennial Change in Expenditures				70		(225)		(225)
Biennial % Change in Expenditures				3		(9)		(9)
Governor's Change from Base								0
Governor's % Change from Base								0
2005 - Opiate Epidemic Response								
Direct Appropriation		2,000	2,000	2,000	2,000	0	2,000	0
Cancellations		175	138					
Expenditures		**1,825**	**1,862**	**2,000**	**2,000**		**2,000**	
Biennial Change in Expenditures				2,037		(1,862)		(1,862)
Biennial % Change in Expenditures						(48)		(48)
Governor's Change from Base								0
Governor's % Change from Base								
3000 - Federal								
Balance Forward In			6					
Receipts	7,556	9,824	10,457	35,025	30,148	24,744	30,148	24,744
Expenditures	**7,556**	**9,824**	**10,462**	**35,025**	**30,148**	**24,744**	**30,148**	**24,744**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Biennial Change in Expenditures				28,107		9,405		9,405
Biennial % Change in Expenditures				162		21		21
Governor's Change from Base								0
Governor's % Change from Base								0

3010 - Coronavirus Relief

Balance Forward In			132					
Direct Appropriation		868						
Cancellations			110					
Balance Forward Out		100						
Expenditures		**768**	**23**					
Biennial Change in Expenditures				(745)		(23)		(23)
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								

Program: Grant Programs
Activity: Children's Mental Health Grants

https://mn.gov/dhs/people-we-serve/children-and-families/health-care/mental-health/

AT A GLANCE

- 154,219 children and youth in Minnesota on Medicaid Programs (under 21 years of age) meet federal criteria for serious emotional disturbance (SED) in CY21.
- In CY21, 81,162 children and youth in Minnesota on Medicaid Programs (under 21 years of age) received publicly funded mental health services.
- 2,488 youth with a severe emotional disturbance received Respite Care Grant services in 2021.
- All funds spending for the Child Mental Grants activity for FY 2021 was $24.88 million. This represented 0.12 percent of the Department of Human Services overall budget.

PURPOSE AND CONTEXT

Children's Mental Health Grants are administered by the Behavioral Health Division of the Behavioral Health, Housing, and Deaf and Hard-of-Hearing Administration (BHDH) , which receives both federal and state funding, to support services for children with mental illness. These grants fund community, school, home, and 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 build providers' capacity to deliver equitable access to effective mental health treatment, promote innovation, and promote integration of mental health services into the state's overall healthcare system. Partners are essential to developing develop and maintaining 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

Children's mental health grant programs include:

- **Children's Respite Grants.** Respite services provide temporary care for children with serious mental health needs who live at home. This program provides relief to families and caregivers while offering a safe environment for their children. These services can be provided in a family's home, foster home, or a licensed facility in the community
- **Children's Evidenced Based-Training Grants.** These grants are awarded to mental health provider agencies serving children and youth for strengthening the clinical infrastructure. The grants are used to provide training and consultation to practicing mental health providers in the use of treatment strategies.
- **Early Childhood Mental Health Capacity Grants.** DHS awards competitive grants to mental health providers to provide early childhood mental health services in Minnesota. There are three core components of the Early Childhood Mental Health (ECMH) grant program: 1)providing appropriate clinical services to young children and their families who are uninsured or underinsured, 2)increasing the clinical competence of clinicians across the state to serve children birth through five and their parents by training them in evidenced-based practices around assessment and treatment of young children and provide mental health consultation to childcare providers across the state to prevent expulsion and suspension of young children from childcare, and 3) increasing childcare staff morale and retention, and addressing the mental health issues of young children and their families accessing childcare.

- **Children's mental health screening grants.** Children's mental health screening grants integrate mental health screening into current practice, promote the use of effective and efficient mental health screening instruments, facilitate referral of children for diagnostic assessments, and make funds available for screening and uncompensated mental health services.
- **Adverse Childhood Experience grants.** This program provides training to Children's Mental Health and Family Services Collaboratives on the impact of ACEs (Adverse Childhood Experiences), brain development, historical trauma, and resilience.
- **Youth Mental Health FIrst Aid grants.** Mental Health First Aid for Youth is a one-day workshop designed to teach parents, family members, caregivers, teachers, school staff, and other citizens how to help an adolescent who is experiencing a mental health or substance use challenge, or who is in crisis.
- **First Episode Psychosis.** First Episode Psychosis (FEP) programs are for all adolescents and young adults ages 15 to 40 experiencing a first episode psychosis, especially underserved and at-risk populations, including African Americans/Africans, American Indians, Asian Americans, Hispanics/Latinos, LGBTQ communities, people with disabilities, and transition age youth.
- **School Linked Mental Health Grants.** These grants provide funding to community mental health agencies that place mental health professionals and practitioners in partnering schools to provide mental health services to students. These mental health providers also consult with teachers, provide care coordination, and offer classroom presentations and school-wide trainings on mental health issues.

RESULTS

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Service Utilization Rate (per 10,000)	501	541	CY2020-CY2021
Quantity	Number of children in the child welfare system who received a mental health screening	7,617	6,408	CY2019-CY2020

Performance 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. An increase in utilization rate denotes an increase in access to services for children.
- 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.

Minnesota Statutes, section 245.4889 (https://www.revisor.mn.gov/statutes/?id=245.4889) provides the legal authority for Children's Mental Health grants.

Child Mental Health Grants

Activity Expenditure Overview

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	22,593	19,471	24,491	36,896	31,830	29,955	48,530	46,676
2001 - Other Misc Special Revenue	29	276	547	420				
2403 - Gift		888						
3000 - Federal	2,887	3,858	2,806	6,986	8,164	8,411	8,164	8,411
3010 - Coronavirus Relief		2,996						
3015 - ARP-State Fiscal Recovery			6,976	8,300				
Total	**25,509**	**27,490**	**34,820**	**52,602**	**39,994**	**38,366**	**56,694**	**55,087**
Biennial Change				34,423		(9,062)		24,359
Biennial % Change				65		(10)		28
Governor's Change from Base								33,421
Governor's % Change from Base								43
Expenditures by Category								
Operating Expenses	561	257	132	80	80	80	80	80
Grants, Aids and Subsidies	24,948	27,233	34,689	52,522	39,914	38,286	56,614	55,007
Total	**25,509**	**27,490**	**34,820**	**52,602**	**39,994**	**38,366**	**56,694**	**55,087**

Child Mental Health Grants

Activity Financing by Fund

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In	2,015	10		4,464				
Direct Appropriation	21,826	21,726	30,167	32,432	31,830	29,955	48,530	46,676
Cancellations	1,238	2,265	1,212					
Balance Forward Out	10		4,464					
Expenditures	**22,593**	**19,471**	**24,491**	**36,896**	**31,830**	**29,955**	**48,530**	**46,676**
Biennial Change in Expenditures				19,323		398		33,819
Biennial % Change in Expenditures				46		1		55
Governor's Change from Base								33,421
Governor's % Change from Base								54
2001 - Other Misc Special Revenue								
Receipts	29	276	547	420				
Expenditures	**29**	**276**	**547**	**420**				
Biennial Change in Expenditures				662		(967)		(967)
Biennial % Change in Expenditures				217		(100)		(100)
Governor's Change from Base								0
Governor's % Change from Base								
2403 - Gift								
Balance Forward In			328	331	331	331	331	331
Receipts		1,213	2					
Balance Forward Out		324	331	331	331	331	331	331
Expenditures		**888**						
Biennial Change in Expenditures				(888)		0		0
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								
3000 - Federal								
Receipts	2,887	3,858	2,806	6,986	8,164	8,411	8,164	8,411
Expenditures	**2,887**	**3,858**	**2,806**	**6,986**	**8,164**	**8,411**	**8,164**	**8,411**
Biennial Change in Expenditures				3,047		6,783		6,783
Biennial % Change in Expenditures				45		69		69

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Governor's Change from Base								0
Governor's % Change from Base								0

3010 - Coronavirus Relief

Direct Appropriation	3,000						
Cancellations	4						
Expenditures	**2,996**						
Biennial Change in Expenditures			(2,996)		0		0
Biennial % Change in Expenditures							
Governor's Change from Base							0
Governor's % Change from Base							

3015 - ARP-State Fiscal Recovery

Balance Forward In			1,500				
Direct Appropriation		8,476	6,800	0	0	0	0
Balance Forward Out		1,500					
Expenditures		**6,976**	**8,300**				
Biennial Change in Expenditures			15,276		(15,276)		(15,276)
Biennial % Change in Expenditures					(100)		(100)
Governor's Change from Base							0
Governor's % Change from Base							

Program: Grant Programs
Activity: Substance Use Disorder (SUD) Treatment Support Grants

https://mn.gov/dhs/people-we-serve/adults/health-care/substance-abuse/

AT A GLANCE

- In the United States in 2020, it is estimated that 25.9 million people over the age of 12 had substance use disorders (SUD).
- 58,563 people in Minnesota received treatment for substance use disorder in CY21.
- 43 percent of people who sought substance use disorder treatment in 2021 completed their program.
- The compulsive gambling helpline receives more than 1,500 calls and texts each year for information or referrals to treatment.
- All funds spending for the SUD Treatment Support and Primary Prevention grant activity for FY21 was $27.9 million, which represented 0.13 percent of the Department of Human Services overall budget.

PURPOSE AND CONTEXT

The Substance Use Disorder (SUD) Treatment Support and Primary Prevention Grants activity uses both federal and state funding to support state-wide prevention, intervention, recovery maintenance, case management and treatment support services for people with alcohol, or drug addiction. Treatment support services include outreach and engagement, assistance with housing-related services, assistance with applying for state benefits, subsidized housing, transportation, childcare, and parenting education.

This activity also includes the state Compulsive Gambling Treatment Program, which funds statewide education, prevention messaging, intervention, treatment and recovery services for individuals and families impacted by problem gambling through evidence-based practices, education, supports, and protective financial resources.

The Opioid Epidemic Response law, raises fees to prescribers, drug manufactures, and distributors. The fee revenue is deposited into the opiate epidemic response fund. The Opiate Epidemic Response Advisory Council has decision-making authority over the allocation of a portion of account funds. The Behavioral Health Division administers grants based on direction from the council.

SERVICES PROVIDED

Substance Use Disorder 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;
- residential substance use treatment for pregnant and parenting mothers and mental health services for the children continuing to reside with them in the treatment setting in order to enable mothers to continue to parent while addressing substance use disorders.
- a statewide prevention resource center that provides education and capacity building to prevent 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 technical assistance and training locally to prevention professionals; and
- a tobacco merchant educational training and compliance check project, as well as funding for Synar inspectors, who conduct random inspections of tobacco retailers.

Most of the funding for SUD 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. Additional funding comes from the Strategic Prevention Framework, Prescription Drug Misuse Prevention grant focusing on the prevention of prescription drug misuse. Funding also comes from the Federal State Opioid Response grant focusing on the prevention of opioid based substances. 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 phone and text help line and problem gambling awareness resources and supports;
- funding for problem gambling assessments, outpatient and residential treatment of problem gambling and gambling addiction;
- compulsive gambling assessments of offenders under section 609.115, subdivision 9;
- training for gambling treatment providers and other behavioral health service providers;
- research focusing on the prevalence of problem gambling and gambling addiction among Minnesotans; 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 racially and ethnically diverse communities that experience higher rates of problem gambling. The Compulsive Gambling statewide helpline, http://www.getgamblinghelp.com/about/, (1-800-333-HOPE or text HOPE to 61222) generally receives about one thousand calls/texts 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 compliance project funds local law enforcement and public health departments to conduct undercover compliance checks and provide educational publications. The project, activated in 2014, 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 Synar Program is required and 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.

SUD/Criminal Justice Involved grants are designed to meet the needs of individuals that experience barriers in accessing SUD treatment due to a felony conviction. They also support reunification with individuals' family and children, when appropriate.

Grants for individuals with substance use disorder who are also at risk of or currently experiencing homelessness to supportcoordination between SUD assessors and providers, and Homeless Coordinated Entry providers to reduce the gaps and barriers for individuals in need of housing and traditional SUD treatment or harm reduction care. These grants enhance access to various core and support services such as outreach/in reach and engagement, housing, substance abuse treatment, mental health care, and benefits advocacy.

Deaf, Deaf/Blind and Hard of Hearing Recovery Support Service Grants provide recovery support services to individuals that are deaf, deaf/blind and/or hard of hearing provide an array of recovery supports intended to reduce barriers such as access to SUD treatment, and ensure availability of aftercare and recovery support services. These grants also develop a pool of individuals qualified to receive peer recovery training.

Opiate Epidemic Response Advisory Council (OERAC)

The OERAC was established to develop and implement a comprehensive and effective statewide effort to address the opioid addiction and overdose epidemic in Minnesota (see Minnesota Statutes, sections 256.042 and 256.043). The council focuses on:

- prevention and education, including public education and awareness for adults and youth, prescriber education, the development and sustainability of opioid overdose prevention and education programs, the role of adult protective services in prevention and response, and providing financial support to local law enforcement agencies for opiate antagonist programs;
- training on the treatment of opioid addiction, including the use of all Food and Drug Administration approved opioid addiction medications, detoxification, relapse prevention, patient assessment, individual treatment planning, counseling, recovery supports, diversion control, and other best practices;
- the expansion and enhancement of a continuum of care for opioid-related substance use disorders, including primary prevention, early intervention, treatment, recovery, and aftercare services; and
- the development of measures to assess and protect the ability of cancer patients and survivors, persons battling life threatening illnesses, persons suffering from severe chronic pain, persons at the end stages of life, and elderly who legitimately need prescription pain medications, to maintain their quality of life by accessing these pain medications without facing unnecessary barriers.

The Behavioral Health Division supports the council and administers grants on the council's behalf.

State Opioid Response (SOR) Grants provide federal funding for:

- Medication assisted treatment (MAT) expansion and recovery resources
- Workforce capacity building
- Naloxone training and distribution
- Expanding navigation and access to MAT
- Innovative response to Minnesota's Opioid Epidemic

Programs funded through SOR aim to address the opioid crisis by increasing access to medication-assisted treatment using the three FDA-approved medications for the treatment of opioid use disorder, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD) (including prescription opioids, heroin and illicit fentanyl and fentanyl analogs).

The Behavioral Health Division, a division of the agency's Community Supports Administration, administers the programs and grants within the SUD Treatment Support Grants activity.

RESULTS

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Result	11th grade use of alcohol, 1-2 days, during the past 30 days.	14%	13%	FY2019 vs FY2021
Result	11th grade use of any tobacco products, including e-cigarettes and hookah, during the past 30 days.	22%	28%	FY2019 vs. FY2021

Measure Notes:

- The use of alcohol and tobacco use measures consist of data reported in the Minnesota Student Survey (https://www.health.state.mn.us/data/mchs/surveys/mss/index.html).

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 SUD Treatment Support and Primary Prevention Grants.

Substance Use Disorder Treatment Support Grants

Activity Expenditure Overview

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	3,595	3,729	3,265	10,781	6,289	4,394	34,839	29,444
2000 - Restrict Misc Special Revenue	215	193	190	378	315	315	315	315
2001 - Other Misc Special Revenue	37	666	210	708	708	693	708	693
2005 - Opiate Epidemic Response		3,223	1,517	6,670	2,415	6,367	8,718	8,063
3000 - Federal	29,786	30,884	34,496	82,489	79,911	42,036	79,911	42,036
4800 - Lottery	1,451	1,732	1,594	1,733	1,733	1,733	1,733	1,733
Total	**35,084**	**40,427**	**41,272**	**102,759**	**91,371**	**55,538**	**126,224**	**82,284**
Biennial Change				68,520		2,878		64,477
Biennial % Change				91		2		45
Governor's Change from Base								61,599
Governor's % Change from Base								42
Expenditures by Category								
Operating Expenses	1,037	1,641	1,080	932	932	932	932	932
Grants, Aids and Subsidies	34,046	38,786	40,193	101,827	90,439	54,606	125,292	81,352
Total	**35,084**	**40,427**	**41,272**	**102,759**	**91,371**	**55,538**	**126,224**	**82,284**
Total Agency Expenditures	35,084	40,427	41,272	102,759	91,371	55,538	126,224	82,284
Internal Billing Expenditures	0							
Expenditures Less Internal Billing	**35,083**	**40,427**	**41,272**	**102,759**	**91,371**	**55,538**	**126,224**	**82,284**

Substance Use Disorder Treatment Support Grants

Activity Financing by Fund

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In	1,420	1,616	1,901	4,601				
Direct Appropriation	3,136	2,636	4,273	4,280	4,247	2,247	32,797	27,297
Receipts	735	1,138	1,760	1,900	2,042	2,147	2,042	2,147
Cancellations	80	13	68					
Balance Forward Out	1,616	1,648	4,601					
Expenditures	**3,595**	**3,729**	**3,265**	**10,781**	**6,289**	**4,394**	**34,839**	**29,444**
Biennial Change in Expenditures				6,722		(3,363)		50,237
Biennial % Change in Expenditures				92		(24)		358
Governor's Change from Base								53,600
Governor's % Change from Base								502
2000 - Restrict Misc Special Revenue								
Balance Forward In	68	404	434	545	545	545	545	545
Receipts	484	135	302	378	315	315	315	315
Balance Forward Out	336	346	545	545	545	545	545	545
Expenditures	**215**	**193**	**190**	**378**	**315**	**315**	**315**	**315**
Biennial Change in Expenditures				160		62		62
Biennial % Change in Expenditures				39		11		11
Governor's Change from Base								0
Governor's % Change from Base								0
2001 - Other Misc Special Revenue								
Balance Forward In	214	227	202	192	123	54	123	54
Receipts		83						
Transfers In	340	540	340	840	840	840	840	840
Transfers Out	300	2	141	201	201	201	201	201
Balance Forward Out	217	182	192	123	54		54	
Expenditures	**37**	**666**	**210**	**708**	**708**	**693**	**708**	**693**
Biennial Change in Expenditures				216		483		483
Biennial % Change in Expenditures				31		53		53
Governor's Change from Base								0
Governor's % Change from Base								0

Substance Use Disorder Treatment Support Grants

Activity Financing by Fund

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
2005 - Opiate Epidemic Response								
Direct Appropriation		3,290	5,398	6,670	2,415	6,367	8,718	8,063
Cancellations		67	3,881					
Expenditures		**3,223**	**1,517**	**6,670**	**2,415**	**6,367**	**8,718**	**8,063**
Biennial Change in Expenditures				4,964		595		8,594
Biennial % Change in Expenditures						7		105
Governor's Change from Base								7,999
Governor's % Change from Base								91
3000 - Federal								
Receipts	29,786	30,884	34,481	82,489	79,911	42,036	79,911	42,036
Transfers In			16					
Expenditures	**29,786**	**30,884**	**34,496**	**82,489**	**79,911**	**42,036**	**79,911**	**42,036**
Biennial Change in Expenditures				56,316		4,962		4,962
Biennial % Change in Expenditures				93		4		4
Governor's Change from Base								0
Governor's % Change from Base								0
4800 - Lottery								
Direct Appropriation	1,733	1,733	1,733	1,733	1,733	1,733	1,733	1,733
Cancellations	282	1	139					
Expenditures	**1,451**	**1,732**	**1,594**	**1,733**	**1,733**	**1,733**	**1,733**	**1,733**
Biennial Change in Expenditures				144		139		139
Biennial % Change in Expenditures				5		4		4
Governor's Change from Base								0
Governor's % Change from Base								0

Program: Direct Care and Treatment

https://mn.gov/dhs/people-we-serve/people-with-disabilities/services/direct-care-treatment/

AT A GLANCE

- Direct Care and Treatment (DCT) offers programs in about 200 sites throughout Minnesota.
- DCT provides services to about 12,000 patients and clients each year.
- DCT has about 4,500 employees and approximately 70% live and work in Greater Minnesota.
- DCT has an annual budget of more than $525 million, which represents less than 3 percent of the overall spending for the Department of Human Services.

PURPOSE AND CONTEXT

Direct Care and Treatment (DCT) is a highly specialized behavioral health care system that serves people with mental illness, chemical dependency, intellectual disabilities, traumatic brain injuries and other serious and often co-occurring conditions.

The only behavioral health care system of its kind, size and scope in Minnesota, DCT occupies a unique niche among the state's health care providers. The system serves patients and clients that other health care providers cannot or will not serve because they do not have the capacity or expertise. Nearly all of the 12,000 patients and clients served each year in DCT facilities have been civilly committed by a court as mentally ill, chemically dependent, developmentally disabled or as sexually dangerous persons. Some patients and clients are under more than one civil commitment. Many face proceedings in criminal courts.

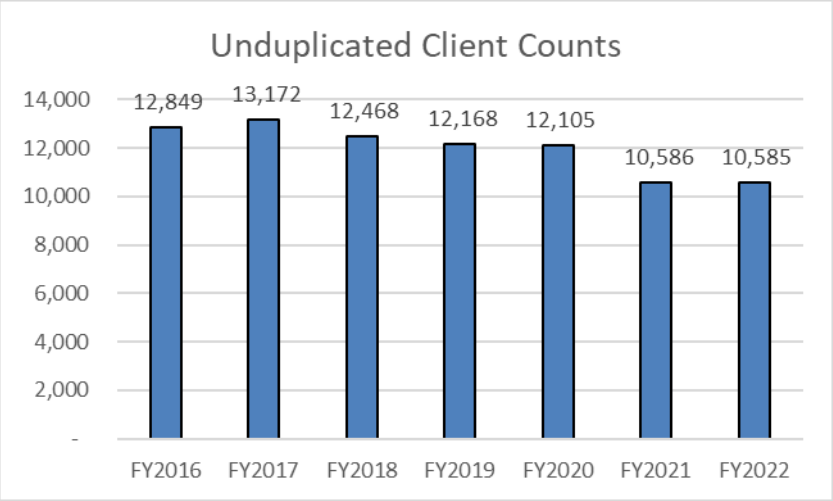
Comparable in size to CentraCare, a health system that covers central Minnesota, DCT's network includes several psychiatric hospitals (including Anoka-Metro Regional Treatment Center, the state's largest psychiatric hospital) and other inpatient mental health treatment facilities; inpatient substance abuse treatment facilities; and special-care dental clinics. DCT's system also includes group homes and vocational sites for people with developmental and intellectual disabilities; and the nation's largest treatment program for civilly committed sex offenders. The system serves 1,850 patients per day for a total of 675,000 patient days per year. Patients and clients are admitted from communities throughout Minnesota.

Treating patients and clients with such complex conditions and often challenging behaviors requires a level of clinical expertise that most other health care systems do not have in such abundance. DCT's has a deep bench of forensic psychiatrists, child psychiatrists, forensic psychologists, neuropsychologists, physicians, special-care dentists and dental support staff, psychiatric and advance-practice registered nurses, pharmacists and other clinicians. In all, more than one-third of DCT's 4,500 employees are highly trained and experienced clinical staff.

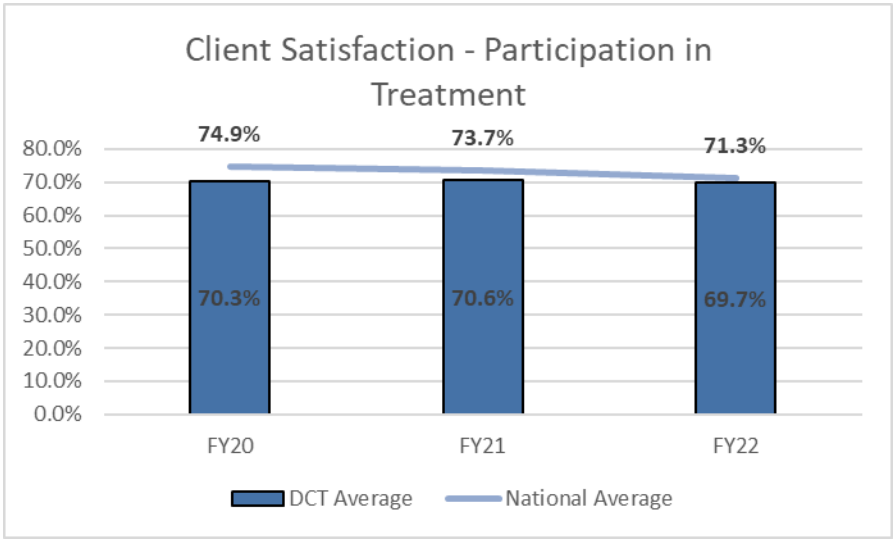
Compared to other health care systems, DCT is also unique in terms of how it is funded and in its authority to manage, downsize or eliminate certain programs or services that have been mandated by the Legislature. For most of its annual operating budget, DCT receives an appropriation from the Legislature. DCT bills Medicare, Medicaid, private insurance, individual patients and all available and allowable sources for all services. Revenue generated is returned to the state General Fund. However, some large DCT programs (inpatient addiction treatment facilities as well as residential and vocational services for people with developmental disabilities) are set up as enterprise programs, meaning they're expected to be self-supporting and operate with the revenue they generate. The reality is some of the programs do not take in enough revenue to be self-sufficient and DCT has often had to request appropriations from the Legislature to close the revenue gap.

Unlike other health care systems, DCT does not have full discretion to upsize, downsize, modify or eliminate programs based on changing patient needs, emerging trends in care and treatment or fiscal realities such as when programs are losing money. Legislative approval is necessary for DCT to make major managerial decisions and operational changes in certain programs and services in response to changes in circumstances.

RESULTS



While the number of patients and clients served has fluctuated between 12,000 and 13,000 since 2016, the COVID-19 pandemic significantly affected admissions to DCT facilities in FY 2021 and FY 2022.



The graph above shows the percentage of patients at discharge or at annual review who respond positively to the inpatient client satisfaction survey. The industry benchmark is 78.41 percent. DCT's target goal is to meet or exceed the industry standard benchmark.

Minnesota Statutes Chapter 246 (https://www.revisor.mn.gov/statutes/cite/246) provides the legal authority for Direct Care and Treatment State Operated Services.

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	356,860	371,731	392,763	427,973	416,736	416,736	490,157	526,065
2000 - Restrict Misc Special Revenue	5,218	6,741	7,710	8,102	7,527	7,623	6,076	6,172
2001 - Other Misc Special Revenue	12,064	9,009	10,164	10,270	10,270	10,270	10,270	10,270
2403 - Gift	3	1	1	4	3	3	3	3
3000 - Federal			273					
3010 - Coronavirus Relief	13,059	3,045						
4100 - SOS TBI & Adol Ent Svcs	1,432	1,281	841	776	798	813	798	813
4101 - DHS Chemical Dependency Servs	16,378	16,202	16,252	18,911	19,315	19,592	0	0
4350 - MN State Operated Comm Svcs	111,996	114,308	121,856	138,247	141,998	144,574	141,998	144,574
4503 - Minnesota State Industries	1,164	738	1,376	1,407	1,407	1,407	1,407	1,407
6000 - Miscellaneous Agency	5,133	5,489	5,494	5,437	5,437	5,437	5,437	5,437
Total	**523,308**	**528,546**	**556,731**	**611,127**	**603,491**	**606,455**	**656,146**	**694,741**
Biennial Change				116,005		42,088		183,029
Biennial % Change				11		4		16
Governor's Change from Base								140,941
Governor's % Change from Base								12
Expenditures by Activity								
Mental Health & Substance Abuse Treatment Services	138,665	137,054	145,768	158,823	157,183	157,460	161,120	168,310
Community Based Services	124,092	126,911	133,605	150,418	152,999	155,590	155,529	159,177
Forensic Services	109,650	116,569	120,588	127,228	128,162	128,162	143,671	151,164
Minnesota Sex Offender Program	93,297	96,459	101,375	107,566	106,569	106,569	120,817	126,623
DCT Administration	57,605	51,552	55,395	67,092	58,578	58,674	75,009	89,467
Total	**523,308**	**528,546**	**556,731**	**611,127**	**603,491**	**606,455**	**656,146**	**694,741**
Expenditures by Category								
Compensation	444,163	450,601	468,110	503,807	505,683	508,647	551,819	579,612
Operating Expenses	71,332	70,172	80,893	100,429	90,917	90,917	97,436	108,238
Grants, Aids and Subsidies	5,984	5,729	5,631	6,891	6,891	6,891	6,891	6,891
Capital Outlay-Real Property	306	433	587					
Other Financial Transaction	1,523	1,612	1,510					

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Total	**523,308**	**528,546**	**556,731**	**611,127**	**603,491**	**606,455**	**656,146**	**694,741**
Total Agency Expenditures	523,308	528,546	556,731	611,127	603,491	606,455	656,146	694,741
Internal Billing Expenditures	217	98	42	161	161	161	161	161
Expenditures Less Internal Billing	**523,091**	**528,448**	**556,689**	**610,966**	**603,330**	**606,294**	**655,985**	**694,580**
Full-Time Equivalents	**4,796.63**	**4,645.50**	**4,534.66**	**4,856.35**	**4,739.00**	**4,670.70**	**5,346.16**	**5,430.42**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		15,096	16,029	6,408				
Direct Appropriation	408,557	416,905	425,441	455,829	451,000	451,000	524,421	560,329
Transfers In	9,409	11,409	14,432					
Transfers Out	46,657	43,460	56,731	34,264	34,264	34,264	34,264	34,264
Cancellations		12,190						
Balance Forward Out	14,449	16,029	6,408					
Expenditures	**356,860**	**371,731**	**392,763**	**427,973**	**416,736**	**416,736**	**490,157**	**526,065**
Biennial Change in Expenditures				92,145		12,736		195,486
Biennial % Change in Expenditures				13		2		24
Governor's Change from Base								182,750
Governor's % Change from Base								22
Full-Time Equivalents	3,223.57	3,135.86	3,079.50	3,347.35	3,230.00	3,161.70	3,837.16	3,921.42
2000 - Restrict Misc Special Revenue								
Balance Forward In	3,731	4,466	3,997	4,506	3,643	1,814	3,643	1,814
Receipts	5,908	5,749	5,718	7,239	5,698	7,630	4,247	6,179
Transfers In		500	2,500					
Transfers Out	2							
Balance Forward Out	4,419	3,974	4,506	3,643	1,814	1,821	1,814	1,821
Expenditures	**5,218**	**6,741**	**7,710**	**8,102**	**7,527**	**7,623**	**6,076**	**6,172**
Biennial Change in Expenditures				3,852		(662)		(3,564)
Biennial % Change in Expenditures				32		(4)		(23)
Governor's Change from Base								(2,902)
Governor's % Change from Base								(19)
Full-Time Equivalents	40.82	40.06	42.02	43.31	43.31	43.31	43.31	43.31
2001 - Other Misc Special Revenue								
Balance Forward In	1,739	369	345	367	369	370	369	370
Receipts	298	1,486	10,186	10,272	10,271	10,271	10,271	10,271
Transfers In	10,395	7,500						
Balance Forward Out	369	345	367	369	370	371	370	371
Expenditures	**12,064**	**9,009**	**10,164**	**10,270**	**10,270**	**10,270**	**10,270**	**10,270**
Biennial Change in Expenditures				(639)		106		106

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Biennial % Change in Expenditures				(3)		1		1
Governor's Change from Base								0
Governor's % Change from Base								0
2400 - Endowment								
Balance Forward In	64	65	65	65	66	67	66	67
Receipts	1	0	0	1	1	1	1	1
Balance Forward Out	65	65	65	66	67	68	67	68
2403 - Gift								
Balance Forward In	46	46	46	47	43	40	43	40
Receipts	3	0	2					
Transfers In		10						
Transfers Out		10						
Balance Forward Out	46	46	46	43	40	37	40	37
Expenditures	**3**	**1**	**1**	**4**	**3**	**3**	**3**	**3**
Biennial Change in Expenditures				1		1		1
Biennial % Change in Expenditures				35		11		11
Governor's Change from Base								0
Governor's % Change from Base								0
3000 - Federal								
Balance Forward In		650						
Receipts	650	7,202	273					
Balance Forward Out	650	7,852						
Expenditures			**273**					
Biennial Change in Expenditures				273		(273)		(273)
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								
3010 - Coronavirus Relief								
Direct Appropriation	13,059	3,045						

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures	**13,059**	**3,045**						
Biennial Change in Expenditures				(16,104)		0		0
Biennial % Change in Expenditures				(100)				
Governor's Change from Base								0
Governor's % Change from Base								

4100 - SOS TBI & Adol Ent Svcs

Balance Forward In	302	542	432	155	183	189	183	189
Receipts	1,670	1,171	565	804	804	804	804	804
Balance Forward Out	540	431	155	183	189	180	189	180
Expenditures	**1,432**	**1,281**	**841**	**776**	**798**	**813**	**798**	**813**
Biennial Change in Expenditures				(1,096)		(6)		(6)
Biennial % Change in Expenditures				(40)		(0)		(0)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	21.40	18.07	10.17	13.20	13.20	13.20	13.20	13.20

4101 - DHS Chemical Dependency Servs

Balance Forward In	2,469	1,778	1,211	80				
Receipts	9,119	8,082	6,684	9,799	10,283	10,560	(9,032)	(9,032)
Transfers In	6,438	7,438	8,438	9,032	9,032	9,032	9,032	9,032
Balance Forward Out	1,648	1,097	80					
Expenditures	**16,378**	**16,202**	**16,252**	**18,911**	**19,315**	**19,592**	**0**	**0**
Biennial Change in Expenditures				2,584		3,744		(35,163)
Biennial % Change in Expenditures				8		11		(100)
Governor's Change from Base								(38,907)
Governor's % Change from Base								(100)
Full-Time Equivalents	141.33	139.37	130.13	150.15	150.15	150.15	150.15	150.15

4350 - MN State Operated Comm Svcs

Balance Forward In	6,396	9,056	15,737	31,367	35,735	37,693	35,735	37,693
Receipts	102,895	120,865	131,364	134,112	135,453	136,808	135,453	136,808
Transfers In	11,697		6,122	8,503	8,503	8,503	8,503	8,503

(Dollars in Thousands)

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY20	FY21	FY22	FY23	FY24	FY25	FY24	FY25
Balance Forward Out	8,992	15,613	31,367	35,735	37,693	38,430	37,693	38,430
Expenditures	**111,996**	**114,308**	**121,856**	**138,247**	**141,998**	**144,574**	**141,998**	**144,574**
Biennial Change in Expenditures				33,798		26,469		26,469
Biennial % Change in Expenditures				15		10		10
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	1,369.51	1,312.14	1,272.84	1,302.34	1,302.34	1,302.34	1,302.34	1,302.34

4503 - Minnesota State Industries

Balance Forward In	2,286	2,702	2,967	2,693	2,156	1,619	2,156	1,619
Receipts	1,502	875	1,102	870	870	870	870	870
Balance Forward Out	2,625	2,838	2,693	2,156	1,619	1,082	1,619	1,082
Expenditures	**1,164**	**738**	**1,376**	**1,407**	**1,407**	**1,407**	**1,407**	**1,407**
Biennial Change in Expenditures				881		31		31
Biennial % Change in Expenditures				46		1		1
Governor's Change from Base								0
Governor's % Change from Base								0

6000 - Miscellaneous Agency

Balance Forward In	876	1,028	1,406	1,277	1,314	1,351	1,314	1,351
Receipts	5,271	5,846	5,365	5,474	5,474	5,474	5,474	5,474
Balance Forward Out	1,014	1,386	1,277	1,314	1,351	1,388	1,351	1,388
Expenditures	**5,133**	**5,489**	**5,494**	**5,437**	**5,437**	**5,437**	**5,437**	**5,437**
Biennial Change in Expenditures				308		(57)		(57)
Biennial % Change in Expenditures				3		(1)		(1)
Governor's Change from Base								0
Governor's % Change from Base								0

Program: Direct Care and Treatment
Activity: Mental Health & Substance Abuse Treatment Services

https://mn.gov/dhs/people-we-serve/people-with-disabilities/services/direct-care-treatment/

AT A GLANCE

- Mental Health and Substance Abuse Teatment Services (MHSATS) provides inpatient and residential services to approximately 300 patients each day.
- The Anoka-Metro Regional Treatment Center (AMRTC) is the state's largest psychiatric hospital. Budgeted to operate 110 beds, AMRTC served 412 patients in FY22.
- The six Community Behavioral Health Hospitals (CBHHs) are 16-bed psychiatric hospitals located across the state. They served 626 patients in FY 2022.
- Community Addiction Recovery Enterprise (C.A.R.E.) programs are 16-bed residential treatment facilities located across the state. They served 375 clients in FY 2022.
- All-funds spending for this budget activity was approximately $142 million for FY 2022, which represents 26 percent of total DCT all-funds spending. Total DCT spending is less than 3 percent of the overall total spending for the Department of Human Services.

PURPOSE AND CONTEXT

Direct Care and Treatment (DCT) is a highly specialized behavioral health care system that serves people with mental illness, substance use disorders, intellectual disabilities, and other serious and often co-occurring conditions. DCT operates psychiatric hospitals and other inpatient mental health treatment facilities; inpatient substance abuse treatment facilities; special-care dental clinics; group homes and vocational sites; and the nation's largest treatment program for civilly committed sex offenders. The system cares for 12,000 patients and clients each year. Because these individuals have conditions that are complex and behaviors that can be challenging, other health care systems cannot or will not serve them. Some providers do not have the capacity; others do not have the expertise.

Mental Health and Substance Abuse Treatment Services (MHSATS) is one of DCT's five main service lines. MHSATS provides inpatient services in eight psychiatric hospitals, five locked addiction treatment facilities, and three short-term residential facilities. The goal is to treat patients as close as possible to their home communities, families, friends, jobs and other supports so that they can make a smooth transition back to life in the community once they're stabilized and ready for discharge.

SERVICES PROVIDED

The following services are funded with general fund appropriations:

- **Anoka-Metro Regional Treatment Center** (**AMRTC):** Inpatient psychiatric services in a secure hospital setting for adults.
- **Community Behavioral Health Hospitals (CBHHs):** Inpatient psychiatric services in a secure hospital setting for adults. Locations in Alexandria, Annandale, Baxter, Bemidji, Fergus Falls, and Rochester.
- **Child & Adolescent Behavioral Health Hospital (CABHH):** Inpatient psychiatric services in a secure hospital setting in Willmar for children and teens.
- **Minnesota Specialty Health System (MSHS):** Inpatient Intensive Residential Treatment Services (IRTS) for adults, located in Brainerd, Wadena and Willmar.

The following service is funded with other revenues:

- **Community Addiction Recovery Enterprise (C.A.R.E.):** Locked inpatient residential treatment for clients with chemical dependency and substance use disorders. Programs operate in Anoka, Carlton, Fergus Falls, St. Peter, and Willmar.

All services are:

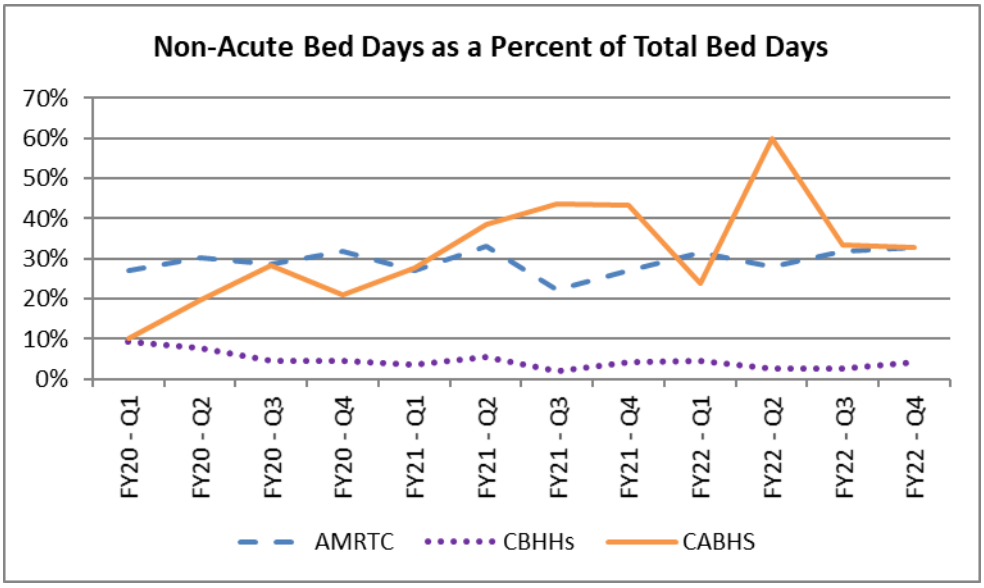
- Patient-centered, focusing on the needs of the individual.
- Provided in a safe environment at the appropriate level of care.
- Designed to allow individuals to move through treatment and into the most integrated setting possible.

To assure a successful transition back to life in the community, we use key strategies such as:

- Collaboration with county and community partners to ensure continuity of services and prompt psychiatric follow-up upon an individual's return to a community setting.
- Reducing the number of medications necessary to control the individual's symptoms.

RESULTS

MHSATS measures non-acute bed days. These are days when a patient who no longer needs a hospital level of care is not discharged in a timely way but remains in the hospital, often due to a lack of community placement options. These delays in discharge are costly and impact the availability of services to other individuals who need hospitalization but cannot be admitted because of a lack of available beds. The goal for hospitals is that less than 10 percent of total bed days be classified as non-acute bed days.

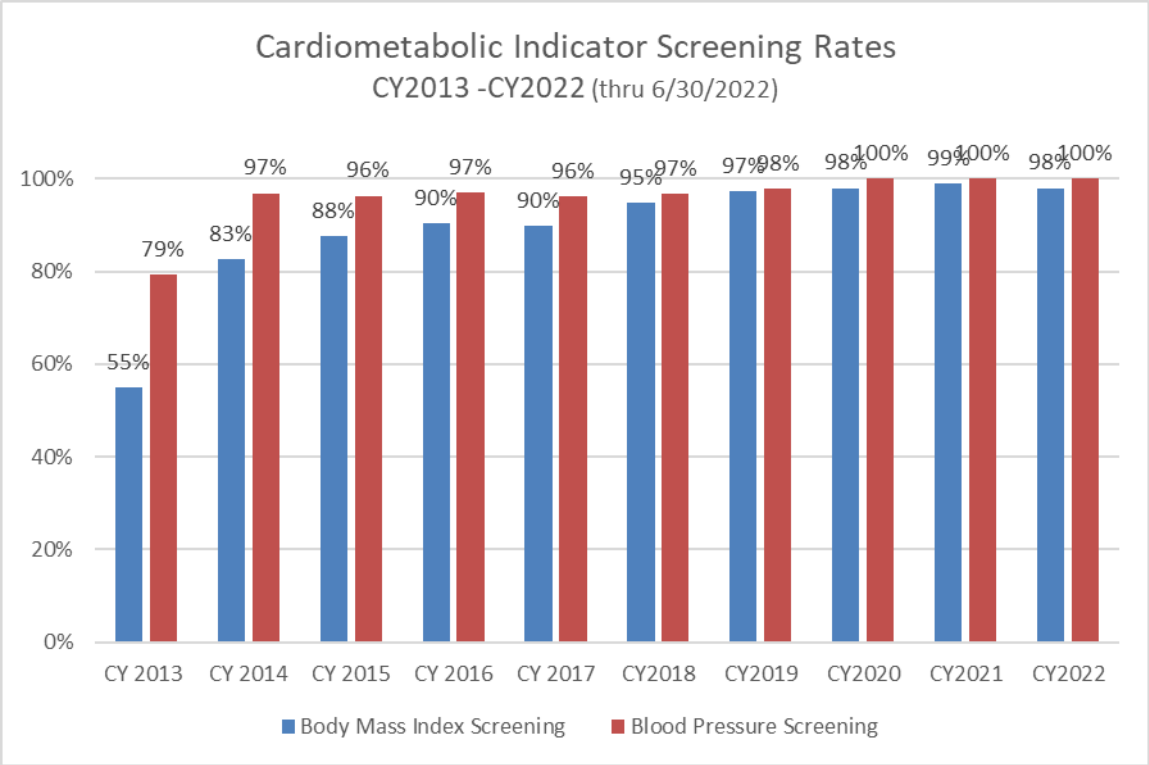


The graph illustrates little change in the trend of non-acute bed days at AMRTC, which is the state's largest psychiatric hospital. On average about 30 percent of bed days at the facility are non-acute bed days.

Non-acute bed days at the CBHHs remain below the 10 percent goal. Because of the lower daily census, non-acute bed days at the CABHH vary widely – or, more directly, one or two clients who do not meet the criteria for hospital level of care greatly impact 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 patients and mirrors national trends towards improving health care 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 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 and monitoring data closely to help patients maintain an appropriate BMI, reduce incidences of chronic disease, and enable them to live healthier lives.

Managing and maintaining a healthy blood pressure reduces risk of cardiovascular disease and other chronic diseases. Increasing the number of people with a healthy blood pressure will help aid patients in leading 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 illustrates the sustained progress that has been made to improve screening for two key components of cardiometabolic syndrome: body mass index (BMI) and blood pressure. MHSATS' goal is to have a 95 percent screening rate for both BMI and blood pressure.

Minnesota Statutes Chapter 246 (https://www.revisor.mn.gov/statutes/?id=246) provide the legal authority for Direct Care and Treatment State Operated Services.

Mental Health & Substance Abuse Treatment Services

Activity Expenditure Overview

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	122,209	120,653	129,343	139,722	137,678	137,678	160,930	168,120
4101 - DHS Chemical Dependency Servs	16,378	16,202	16,252	18,911	19,315	19,592	0	0
6000 - Miscellaneous Agency	78	200	173	190	190	190	190	190
Total	**138,665**	**137,054**	**145,768**	**158,823**	**157,183**	**157,460**	**161,120**	**168,310**
Biennial Change				28,872		10,052		24,839
Biennial % Change				10		3		8
Governor's Change from Base								14,787
Governor's % Change from Base								5
Expenditures by Category								
Compensation	118,681	119,775	123,775	132,842	133,246	133,523	137,183	144,373
Operating Expenses	19,748	16,972	21,106	25,770	23,726	23,726	23,726	23,726
Grants, Aids and Subsidies	82	202	175	211	211	211	211	211
Capital Outlay-Real Property			572					
Other Financial Transaction	154	106	140					
Total	**138,665**	**137,054**	**145,768**	**158,823**	**157,183**	**157,460**	**161,120**	**168,310**
Total Agency Expenditures	138,665	137,054	145,768	158,823	157,183	157,460	161,120	168,310
Internal Billing Expenditures	15	10	3	7	7	7	7	7
Expenditures Less Internal Billing	**138,650**	**137,045**	**145,764**	**158,816**	**157,176**	**157,453**	**161,113**	**168,303**
Full-Time Equivalents	**1,229.00**	**1,169.94**	**1,117.64**	**1,254.51**	**1,221.82**	**1,199.16**	**1,524.30**	**1,547.98**

Mental Health & Substance Abuse Treatment Services

Activity Financing by Fund

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		3,105		2,044				
Direct Appropriation	129,209	129,201	137,934	146,710	146,710	146,710	169,962	177,152
Transfers In	3,500		1,000					
Transfers Out	7,626	8,126	7,547	9,032	9,032	9,032	9,032	9,032
Cancellations		3,527						
Balance Forward Out	2,874		2,044					
Expenditures	**122,209**	**120,653**	**129,343**	**139,722**	**137,678**	**137,678**	**160,930**	**168,120**
Biennial Change in Expenditures				26,203		6,291		59,985
Biennial % Change in Expenditures				11		2		22
Governor's Change from Base								53,694
Governor's % Change from Base								20
Full-Time Equivalents	1,086.56	1,030.57	987.51	1,104.36	1,071.67	1,049.01	1,374.15	1,397.83
2000 - Restrict Misc Special Revenue								
Full-Time Equivalents	1.11							
4101 - DHS Chemical Dependency Servs								
Balance Forward In	2,469	1,778	1,211	80				
Receipts	9,119	8,082	6,684	9,799	10,283	10,560	(9,032)	(9,032)
Transfers In	6,438	7,438	8,438	9,032	9,032	9,032	9,032	9,032
Balance Forward Out	1,648	1,097	80					
Expenditures	**16,378**	**16,202**	**16,252**	**18,911**	**19,315**	**19,592**	**0**	**0**
Biennial Change in Expenditures				2,584		3,744		(35,163)
Biennial % Change in Expenditures				8		11		(100)
Governor's Change from Base								(38,907)
Governor's % Change from Base								(100)
Full-Time Equivalents	141.33	139.37	130.13	150.15	150.15	150.15	150.15	150.15
6000 - Miscellaneous Agency								
Balance Forward In	2	13	7	12	13	14	13	14
Receipts	89	194	178	191	191	191	191	191
Balance Forward Out	13	7	12	13	14	15	14	15
Expenditures	**78**	**200**	**173**	**190**	**190**	**190**	**190**	**190**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Biennial Change in Expenditures				85		17		17
Biennial % Change in Expenditures				31		5		5
Governor's Change from Base								0
Governor's % Change from Base								0

Program: Direct Care and Treatment
Activity: Community Based Services

https://mn.gov/dhs/people-we-serve/people-with-disabilities/services/direct-care-treatment/

AT A GLANCE

- Community Based Services (CBS) provides residential, vocational and other support services for more than 500 people with developmental disabilities and other complex behavioral needs each day.
- Community Support Services mobile teams provided support to 315 people in FY 2022.
- CBS foster care program served 13 children and adolescents with severe emotional disturbances in individual foster homes in FY 2022.
- CBS residential programs served 333 clients in FY 2022.
- CBS vocational program served 515 clients in FY 2022.
- All-funds spending for this budget activity was approximately $132 million for FY2022. This represents 24 percent of total Direct Care and Treatment (DCT) all-funds spending. Total DCT spending is less than 3 percent of the overall spending for the Department of Human Services.

PURPOSE AND CONTEXT

Direct Care and Treatment (DCT) is a highly specialized behavioral health care system that serves people with mental illness, substance use disorders, intellectual disabilities, and other serious and often co-occurring conditions. DCT operates psychiatric hospitals and other inpatient mental health treatment facilities; inpatient substance abuse treatment facilities; special-care dental clinics; group homes and vocational sites; and the nation's largest treatment program for civilly committed sex offenders. The system cares for 12,000 patients and clients each year. Because these individuals have conditions that are complex and behaviors that can be challenging, other health care systems cannot or will not serve them. Some providers do not have the capacity; others do not have the expertise.

Community Based Services (CBS) is one of DCT's five main service lines. CBS provides treatment and residential supports to individuals with developmental disabilities and complex behavioral health needs for whom no other providers are available. The majority of CBS programs operate as enterprise services, which means funding relies 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)**: Specialized mobile teams provide crisis support services statewide to individuals with mental illness and/or disabilities who are living in their home community or transitioning back to their home community. The 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 inpatient treatment settings.
- **Crisis Residential Services and Minnesota Life Bridge (CRS and MLB)**: CRS and MLB have a total of eight short-term residential programs throughout the state. The goal is to support clients in the most integrated setting close to their home communities or near families, friends, and other supportive people while addressing behavior associated with mental illness or intellectual disabilities that could cause individuals to lose their residential placements or be admitted to a less integrated setting.

- **Child and Adolescent Services (CAS):** These services for youth ranging from short-term crisis residential placements to foster care. Short-term crisis residential programs provide support to youth exhibiting behaviors related to intellectual disabilities and/or mental illness with a goal of finding long-term placement. The Minnesota Intensive Therapeutic Homes (MITH) program provides foster care to children and adolescents who have severe emotional disturbances and challenging behaviors. Homes are located throughout the state. Treatment is tailored to the needs of each child and is based on a combination of multidimensional treatment, wrap-around services and specialized behavior therapy.
- **CBS Residential Services**: Operates about 100 small group homes (typically four beds) located throughout Minnesota for individuals with mental illness and/or developmental disabilities. Staff assist clients with activities of daily living, provide therapeutic support and help them live, work and be involved in their local communities. Service rates are set through the Rate Management System (RMS) for each client based on individual needs. The program is a transitional service that keeps clients from being placed in less integrated settings such as jails, hospitals, and institutions. It also helps transition clients out of segregated or secure settings and into community life. As clients improve and no longer require the level of care they receive in a CBS-operated home, they move to homes operated by private entities. Many clients (and entire CBS-operated homes) have been successfully transitioned to private care providers. This allows CBS to continue serving the most behaviorally complex individuals.
- **CBS Vocational Services**: Provides vocational support services for people with developmental disabilities, including evaluations, training, and onsite coaching and assistance for clients working jobs in the community. Service rates are generated for each client based on individual needs.

RESULTS

Type of Measure	***Name of Measure***	***Previous***	***Current***	***Dates***
Quantity	The percentage of survey respondents who said support from CSS mobile teams prevented placement in a less integrated setting (jails, hospitals, institutional settings, etc).	76%	81%	2019 v. 2022
Quantity	The percentage of vocational services clients employed in their communities.	66%	84%	June 2020 v. June 2022
Type of Measure	***Description of Measure***	***Transitions/ Dicharges***	***Admissions***	***Dates***
Quantity	Clients who no longer required CBS services and were transitioned to other providers; and clients admitted who have complex behavioral needs that cannot be supported by other providers.	337	208	2017 to 2022
Quantity	Crisis Residential Services and Minnesota Life Bridge admissions and discharges	161	159	2017 to 2022

Minnesota Statutes Chapter 246 (https://www.revisor.mn.gov/statutes/?id=246) provide the legal authority for Direct Care and Treatment State Operated Services.

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	10,661	11,316	10,902	11,381	10,190	10,190	12,720	13,777
2000 - Restrict Misc Special Revenue	0	5	4	10	10	10	10	10
2403 - Gift	2	1	1	4	3	3	3	3
4100 - SOS TBI & Adol Ent Svcs	1,432	1,281	841	776	798	813	798	813
4350 - MN State Operated Comm Svcs	111,996	114,308	121,856	138,247	141,998	144,574	141,998	144,574
Total	**124,092**	**126,911**	**133,605**	**150,418**	**152,999**	**155,590**	**155,529**	**159,177**
Biennial Change				33,020		24,566		30,683
Biennial % Change				13		9		11
Governor's Change from Base								6,117
Governor's % Change from Base								2
Expenditures by Category								
Compensation	112,761	115,042	119,288	135,011	138,518	141,109	141,048	144,696
Operating Expenses	10,835	11,517	13,776	14,951	14,025	14,025	14,025	14,025
Grants, Aids and Subsidies	423	259	351	456	456	456	456	456
Capital Outlay-Real Property		1	0					
Other Financial Transaction	73	92	190					
Total	**124,092**	**126,911**	**133,605**	**150,418**	**152,999**	**155,590**	**155,529**	**159,177**
Total Agency Expenditures	124,092	126,911	133,605	150,418	152,999	155,590	155,529	159,177
Internal Billing Expenditures	88	68	25	13	13	13	13	13
Expenditures Less Internal Billing	**124,004**	**126,843**	**133,580**	**150,405**	**152,986**	**155,577**	**155,516**	**159,164**
Full-Time Equivalents	**1,488.93**	**1,422.65**	**1,373.12**	**1,421.24**	**1,415.16**	**1,413.05**	**1,439.39**	**1,442.36**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		405		95				
Direct Appropriation	22,752	11,055	17,292	19,789	18,693	18,693	21,223	22,280
Transfers In	1,000	1,500						
Transfers Out	12,697	1,000	6,295	8,503	8,503	8,503	8,503	8,503
Cancellations		645						
Balance Forward Out	394		95					
Expenditures	**10,661**	**11,316**	**10,902**	**11,381**	**10,190**	**10,190**	**12,720**	**13,777**
Biennial Change in Expenditures				307		(1,903)		4,214
Biennial % Change in Expenditures				1		(9)		19
Governor's Change from Base								6,117
Governor's % Change from Base								30
Full-Time Equivalents	98.02	92.44	90.11	105.70	99.62	97.51	123.85	126.82
2000 - Restrict Misc Special Revenue								
Balance Forward In	105	119	136	150	150	150	150	150
Receipts	14	22	18	10	10	10	10	10
Balance Forward Out	119	136	150	150	150	150	150	150
Expenditures	**0**	**5**	**4**	**10**	**10**	**10**	**10**	**10**
Biennial Change in Expenditures				8		6		6
Biennial % Change in Expenditures				145		43		43
Governor's Change from Base								0
Governor's % Change from Base								0
2403 - Gift								
Balance Forward In	38	37	36	36	32	29	32	29
Receipts	1	0	1					
Transfers In		2						
Transfers Out		2						
Balance Forward Out	37	36	36	32	29	26	29	26
Expenditures	**2**	**1**	**1**	**4**	**3**	**3**	**3**	**3**
Biennial Change in Expenditures				2		1		1
Biennial % Change in Expenditures				76		11		11
Governor's Change from Base								0

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Governor's % Change from Base								0

4100 - SOS TBI & Adol Ent Svcs

Balance Forward In	186	423	313	36	63	68	63	68
Receipts	1,668	1,170	564	803	803	803	803	803
Balance Forward Out	422	312	36	63	68	58	68	58
Expenditures	**1,432**	**1,281**	**841**	**776**	**798**	**813**	**798**	**813**
Biennial Change in Expenditures				(1,096)		(6)		(6)
Biennial % Change in Expenditures				(40)		(0)		(0)
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	21.40	18.07	10.17	13.20	13.20	13.20	13.20	13.20

4350 - MN State Operated Comm Svcs

Balance Forward In	6,396	9,056	15,737	31,367	35,735	37,693	35,735	37,693
Receipts	102,895	120,865	131,364	134,112	135,453	136,808	135,453	136,808
Transfers In	11,697		6,122	8,503	8,503	8,503	8,503	8,503
Balance Forward Out	8,992	15,613	31,367	35,735	37,693	38,430	37,693	38,430
Expenditures	**111,996**	**114,308**	**121,856**	**138,247**	**141,998**	**144,574**	**141,998**	**144,574**
Biennial Change in Expenditures				33,798		26,469		26,469
Biennial % Change in Expenditures				15		10		10
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	1,369.51	1,312.14	1,272.84	1,302.34	1,302.34	1,302.34	1,302.34	1,302.34

Program: Direct Care and Treatment
Activity: Forensic Services

https://mn.gov/dhs/people-we-serve/people-with-disabilities/services/direct-care-treatment/

AT A GLANCE

- More than 400 individuals received mental health treatment and services during FY 2022. However, Forensic Services has seen a reduction in both admissions and discharges.
- As of June 30, 2022, 18 patients civilly committed by the court as mentally ill and dangerous (MI&D) were on a waiting list for admission to Forensic Services due to an increase in the number of civil commitments.
- More than 500 individuals were evaluated for competency to stand trial during FY 2022.
- The Forensic Nursing Home served 40 individuals during FY 2022.
- Currently, 243 individuals civilly committed as MI&D are on provisional discharge from Forensic Services and living successfully in Minnesota communities.
- All-funds spending for this budget activity was approximately $120 million for FY 2022. This represents 22 percent of the total Direct Care and Treatment (DCT) all-funds spending. Total DCT spending is less than 3 percent of the overall spending for the Department of Human Services.

PURPOSE AND CONTEXT

Direct Care and Treatment (DCT) is a highly specialized behavioral health care system that serves people with mental illness, substance use disorders, intellectual disabilities, and other serious and often co-occurring conditions. DCT operates psychiatric hospitals and other inpatient mental health treatment facilities; inpatient substance abuse treatment facilities; special-care dental clinics; group homes and vocational sites; and the nation's largest treatment program for civilly committed sex offenders. The system cares for 12,000 patients and clients each year. Because these individuals have conditions that are complex and behaviors that can be challenging, other health care systems cannot or will not serve them. Some providers do not have the capacity; others do not have the expertise.

Forensic Services (FS) is one of DCT's five main service lines. At secure and non-secure facilities in St. Peter, MN, Forensic Services provides evaluation and specialized mental health treatment services to clients whom the courts have civilly committed as mentally ill and dangerous (MI&D).

- Forensic Services provides multidisciplinary treatment services to adults with severe and persistent mental illness who have come in contact with the criminal justice system, often because they have committed a serious crime and a court has determined that they pose a danger to themselves, others, or the public.
- Clients are admitted to Forensic Services from anywhere in Minnesota as a result of civil commitment. Most have been committed as mentally ill and dangerous (MI&D), although all other commitment types are admitted.
- The $126-million expansion and renovation of the Forensic Services facilities in St. Peter was completed in early 2022. The project was authorized and funded by the Legislature with General Obligation bonds in two phases with a goal of creating safer and more therapeutic living units and more transition housing for patients and providing safer working conditions for staff. The $56.3 million Phase I was approved in the 2014 Capital Investment bill and was completed in late 2016. That phase added 147,000 square feet of new construction. Construction on the $70.25 million Phase II, which included a major remodeling of 100,000 square feet and new construction of another 87,000 square feet, was approved in the 2017 Capital Investment bill and was completed this year.

SERVICES PROVIDED

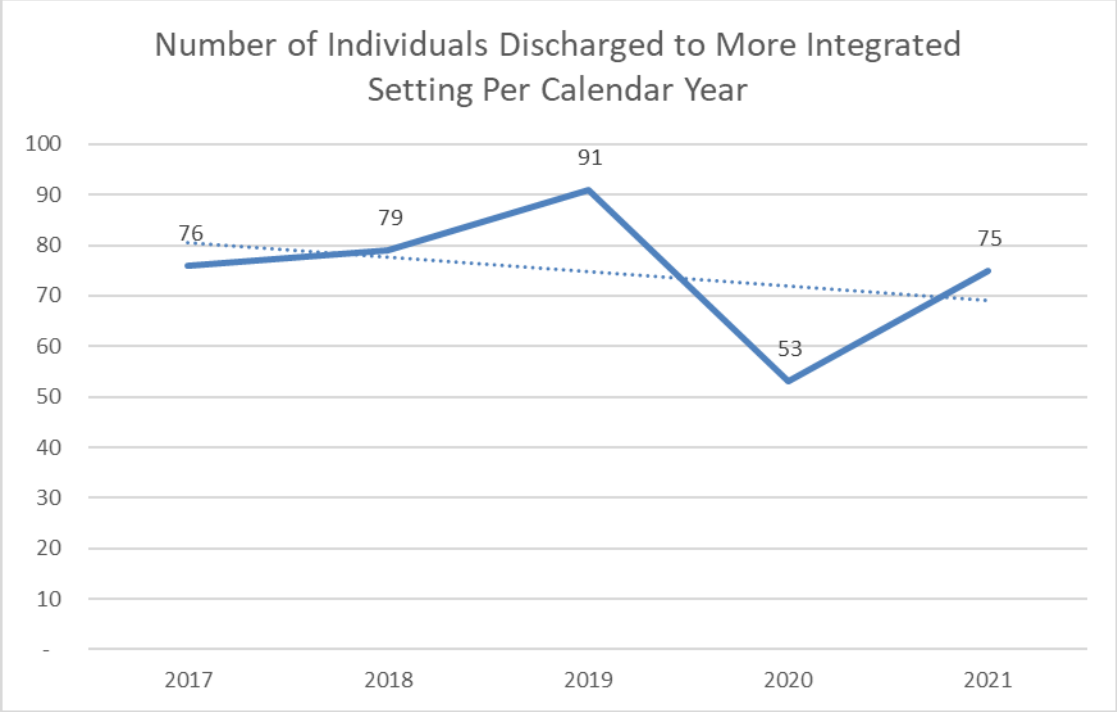
Forensics Services provides a continuum of care:

- **Forensic Mental Health Program (FMHP)**: Provides secure and non-secure inpatient treatment of individuals with chronic persistent mental illness who are committed primarily as MI&D. From the time of admission, treatment focuses on long-term stabilization and prepares patients for eventual provisional discharge and re-entry into the community. The FMHP also includes a 34- bed facility off the main campus in St. Peter which houses patients who have received permission from the Special Review Board to reside in a non-secure treatment facility.
- **Court-ordered evaluations:** A team of forensic examiners provides competency and pre-sentencing mental health evaluations. These can be done on either an inpatient basis within Forensic Services or in a community setting, including jails.
- **Forensic Nursing Home (FNH):** Minnesota's only state-operated nursing home, the FNH provides a secure licensed nursing home setting for individuals who are committed as MI&D, sexual psychopathic personality (SPP), and sexually dangerous person (SDP) and prison inmates on a medical release from the Department of Corrections. Treatment focus is similar to all nursing homes with provision activities of daily living care, rehabilitation services, and end of life care.

All of these services are provided through a direct general fund appropriation except for court-ordered evaluations, which are funded with other revenues.

RESULTS

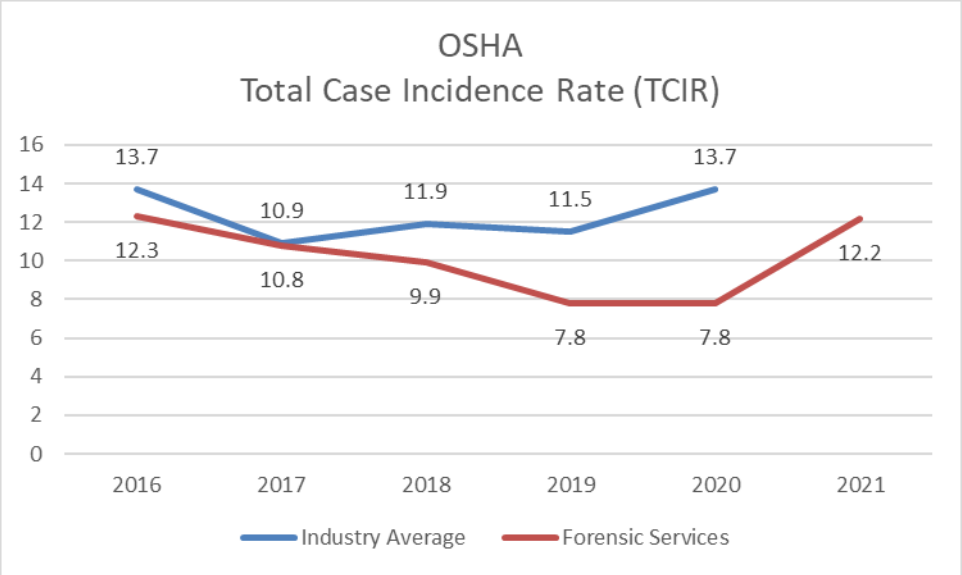
We measure success by the number of individuals discharged from Forensic Services programs to more integrated settings in the community, consistent with Minnesota's Olmstead Plan. In the chart below, the solid line is the average number of discharges. The dotted line is the trend line over the past three years.



During the second half of FY 2018, there was an increase in the number of individuals discharged to more integrated settings. In calendar year 2020 (third and fourth quarters of fiscal year 2020), there was a reduction in the number of individuals discharged to more integrated settings. Several factors contributed to this reduction, including the coronavirus pandemic. Specific factors include reduced reintegration efforts and community

provider capacity due to COVID, as well as the clinical impacts to patients resulting from stress and uncertainty of COVID and community unrest following the death of George Floyd.

The safety of our clients and staff is our top priority. One measure of safety is the Occupational Safety and Health Administration (OSHA) Total Case Incidence Rate (TCIR). The OSHA Total Case Incident Rate is the total number of workplace injuries or illnesses per 100 full-time employees (FTE) working in a year. This is a metric used nationally to compare rates of workplace injuries with national averages of similar industries, which in the case of Forensic Services is state health care nursing and residential facilities. In the chart below, the blue line is the annual data for Forensic Treatment Services (FTS). The orange line denotes the industry code average rate for state government nursing and residential facilities.



Many efforts contributed to the reduction in TCIR over the past four calendar years, including:

- Facility renovations that have created a more therapeutic environment that is safer for patients and the staff who care for them.
- Stabilized staffing and reduced staff turnover. Psychiatric providers, nursing staff and clinical staff provide clinical direction that takes the unique needs of individual patients into account and guides more effective treatment.
- Increase in clinical staff providing programming such as 1:1 and group therapy, social skill development through recreational and occupational therapies, music and art therapy, medication education, spiritual services, reintegration activities and vocational skills development.
- Increase in the number of support staff who work with patients and reinforce skills practiced in groups and strategies for managing stressors, mental health crisis, free time, completion of normal day activities.
- Rewriting training curriculum to eliminate inconsistencies; training and/or retraining staff; and continuing to monitor how staff follow and implement training.
- Initiating a monthly Safety Team meeting with membership of staff who work on all shifts to review all staff and patients injures from the previous month. The team focuses on what went well, what didn't go well, training needs and opportunities for improvement.

Minnesota Statutes Chapter 246 (https://www.revisor.mn.gov/statutes/?id=246) provide the legal authority for State Operated Services. See also, Minnesota Statutes Chapter 253 (https://www.revisor.mn.gov/statutes/?id=253) for additional authority that is specific to Forensic Services.

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	107,414	114,014	118,165	124,577	125,511	125,511	141,020	148,513
2000 - Restrict Misc Special Revenue	715	768	755	894	894	894	894	894
6000 - Miscellaneous Agency	1,520	1,787	1,669	1,757	1,757	1,757	1,757	1,757
Total	**109,650**	**116,569**	**120,588**	**127,228**	**128,162**	**128,162**	**143,671**	**151,164**
Biennial Change				21,598		8,508		47,019
Biennial % Change				10		3		19
Governor's Change from Base								38,511
Governor's % Change from Base								15
Expenditures by Category								
Compensation	100,297	106,626	111,309	112,639	113,573	113,573	129,082	136,575
Operating Expenses	7,354	7,733	7,438	12,670	12,670	12,670	12,670	12,670
Grants, Aids and Subsidies	1,797	1,862	1,625	1,919	1,919	1,919	1,919	1,919
Capital Outlay-Real Property	27	45						
Other Financial Transaction	173	303	216					
Total	**109,650**	**116,569**	**120,588**	**127,228**	**128,162**	**128,162**	**143,671**	**151,164**
Total Agency Expenditures	109,650	116,569	120,588	127,228	128,162	128,162	143,671	151,164
Internal Billing Expenditures	0	0	0					
Expenditures Less Internal Billing	**109,649**	**116,569**	**120,588**	**127,228**	**128,162**	**128,162**	**143,671**	**151,164**
Full-Time Equivalents	**1,035.15**	**1,028.68**	**1,002.52**	**1,032.57**	**1,011.06**	**989.75**	**1,120.53**	**1,145.54**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		3,657		162				
Direct Appropriation	112,126	115,342	119,206	124,415	125,511	125,511	141,020	148,513
Transfers Out	1,123	3,123	880					
Cancellations		1,861						
Balance Forward Out	3,589		162					
Expenditures	**107,414**	**114,014**	**118,165**	**124,577**	**125,511**	**125,511**	**141,020**	**148,513**
Biennial Change in Expenditures				21,313		8,280		46,791
Biennial % Change in Expenditures				10		3		19
Governor's Change from Base								38,511
Governor's % Change from Base								15
Full-Time Equivalents	1,033.08	1,026.59	999.37	1,029.42	1,007.91	986.60	1,117.38	1,142.39
2000 - Restrict Misc Special Revenue								
Balance Forward In	587	756	780	877	883	889	883	889
Receipts	865	790	852	900	900	900	900	900
Balance Forward Out	737	778	878	883	889	895	889	895
Expenditures	**715**	**768**	**755**	**894**	**894**	**894**	**894**	**894**
Biennial Change in Expenditures				166		139		139
Biennial % Change in Expenditures				11		8		8
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	2.07	2.09	3.15	3.15	3.15	3.15	3.15	3.15
6000 - Miscellaneous Agency								
Balance Forward In	265	291	378	259	231	203	231	203
Receipts	1,534	1,874	1,549	1,729	1,729	1,729	1,729	1,729
Balance Forward Out	279	378	259	231	203	175	203	175
Expenditures	**1,520**	**1,787**	**1,669**	**1,757**	**1,757**	**1,757**	**1,757**	**1,757**
Biennial Change in Expenditures				119		88		88
Biennial % Change in Expenditures				4		3		3
Governor's Change from Base								0
Governor's % Change from Base								0

Program: Direct Care and Treatment
Activity: Minnesota Sex Offender Program

https://mn.gov/dhs/people-we-serve/adults/services/sex-offender-treatment/

AT A GLANCE

- Clients progress through three phases of sex-offender-specific treatment.
- As of June 30, 2022:
  - Minnesota Sex Offender Program (MSOP) client population was 739.
  - 38 MSOP clients were on provisional discharge and living in the communities under MSOP supervision. Another 10 or fewer had been granted provisional discharge and were waiting for community placement.
  - 72 MSOP clients have received a provisional discharge order in the history of the program.
  - 16 MSOP clients have been fully discharged from their commitment.
  - About 88 percent of MSOP clients voluntarily participated in treatment.
- All-funds spending for this budget activity was approximately $99 million for FY 2022. This represents 18 percent of the total Direct Care and Treatment (DCT) all-funds spending. Total DCT spending is less than 3 percent of the overall spending for the Department of Human Services.

PURPOSE AND CONTEXT

Direct Care and Treatment (DCT) is a highly specialized behavioral health care system that serves people with mental illness, substance use disorders, intellectual disabilities, and other serious and often co-occurring conditions. DCT operates psychiatric hospitals and other inpatient mental health treatment facilities; inpatient substance abuse treatment facilities; special-care dental clinics; group homes and vocational sites; and the nation's largest treatment program for civilly committed sex offenders. The system cares for 12,000 patients and clients each year. Because these individuals have conditions that are complex and behaviors that can be challenging, other health care systems cannot or will not serve them. Some providers do not have the capacity; others do not have the expertise.

The Minnesota Sex Offender Program (MSOP) is one of DCT's five main service lines. MSOP operates secure treatment facilities in Moose Lake and St. Peter for civilly committed sex offenders. It also operates Community Preparation Services, a less restrictive treatment setting on the St. Peter campus.

- MSOP's mission is to promote public safety by providing comprehensive sex offender treatment and reintegration opportunities for sexual abusers.
- Minnesota is one of 20 states with civil commitment laws for sex offenders and is the largest program of its kind in the country.
- There are approximately 15 to 20 new commitments annually. Only a court has the authority to admit clients to MSOP.
- Most MSOP clients have served prison sentences prior to their civil commitment.
- Transfer to less restrictive settings, such as Community Preparation Services, provisional discharge, or full discharge from MSOP, occurs by court order from a three judge panel. Only the court has authority to discharge clients.

SERVICES PROVIDED

We accomplish our mission by:

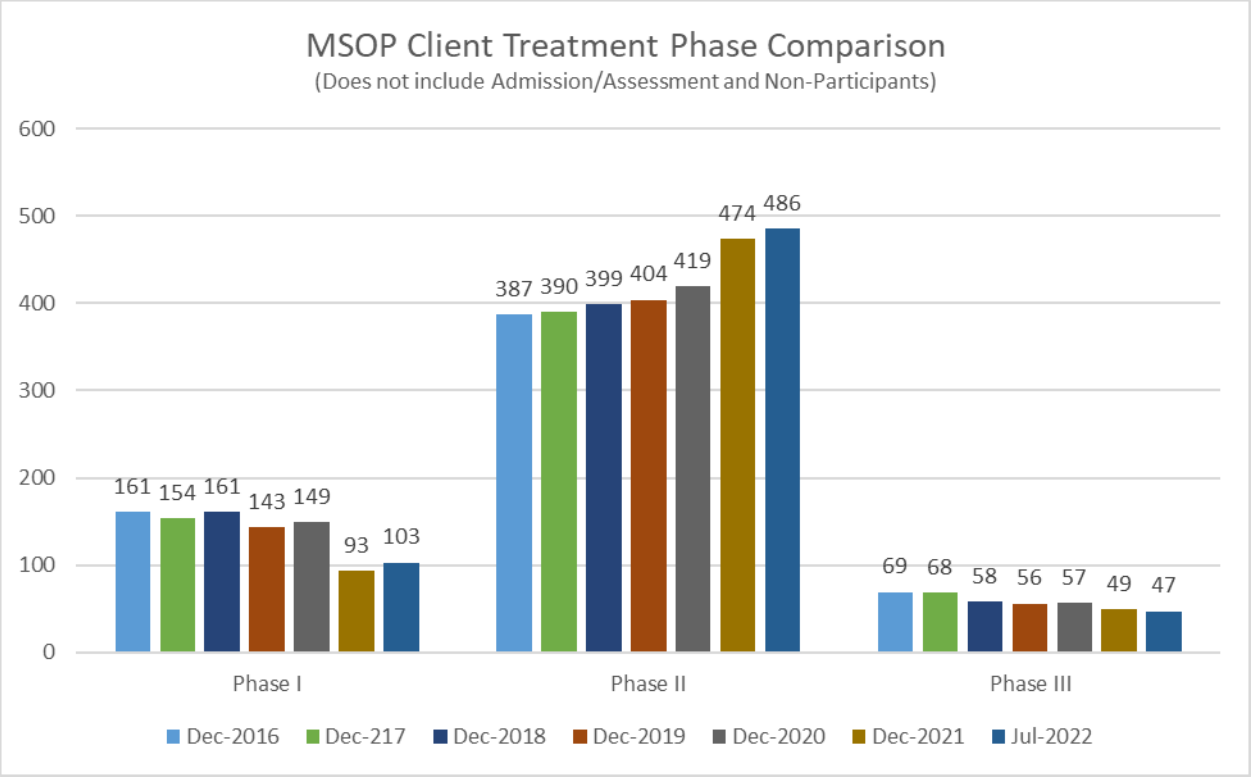
- Maintaining a therapeutic treatment environment that is safe and conducive for making positive behavioral change.
- Providing core group therapy, psycho-educational modules, and other treatment. Clients also participate in rehabilitative services that include education, therapeutic recreation, and vocational program work assignments.
- Providing risk assessments, treatment reports, and testimony that inform the courts.
- Working together with communities, policymakers, and other governmental agencies.
- Providing supervision and resources to help provisionally discharged clients succeed in the community.

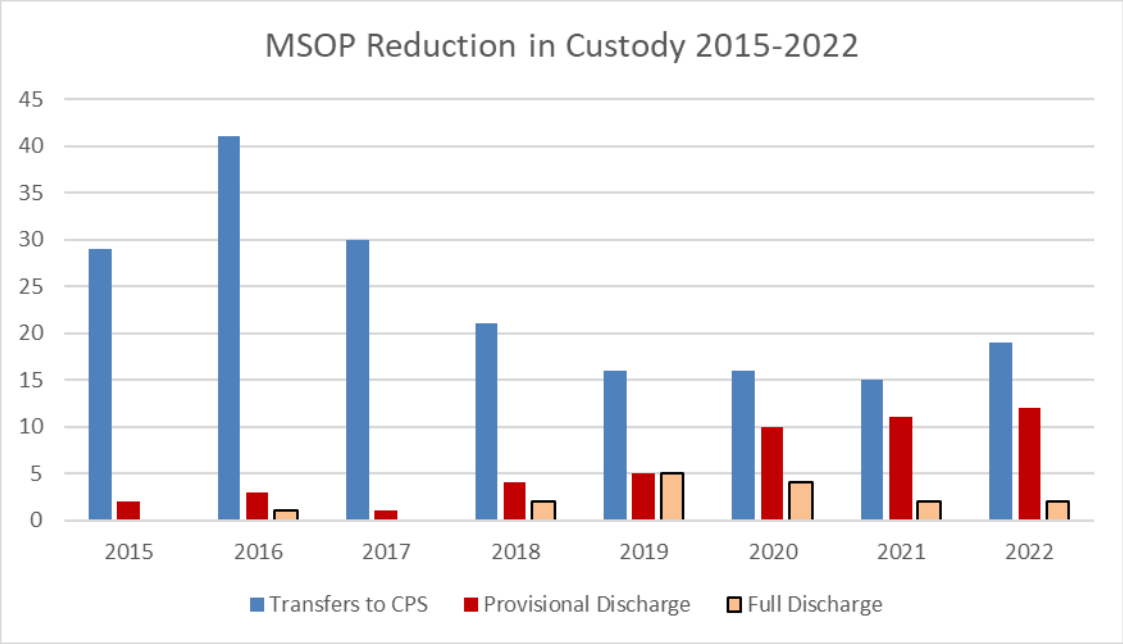
MSOP is a three-phase treatment program. In Phase I, clients initially address treatment-interfering behaviors and attitudes. Phase II focuses on clients' patterns of abuse and identifying and resolving the underlying issues in their offenses. Clients in Phase III focus on deinstitutionalization and reintegration, applying the skills they acquired in treatment across settings and maintaining the changes they have made while managing their risk for reoffense.

MSOP is funded by general fund appropriations. When a court commits someone to the program, the county in which they are committed is responsible for part of the cost of care. For commitments initiated 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 a 25-percent 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 since 2013.





[1] The number of new contracts with a start date in each fiscal year across DCT. Some contract may have

Results Notes

- Treatment progression graph is produced by the MSOP Research Department.

Minnesota Statutes, chapter 246B (https://www.revisor.mn.gov/statutes/cite/246B) governs the operation of the Sex Offender Program and chapter https://www.revisor.mn.gov/statutes/cite/253D governs the civil commitment and treatment of sex offenders.

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	88,600	92,218	96,347	102,669	101,672	101,672	115,920	121,726
4503 - Minnesota State Industries	1,164	738	1,376	1,407	1,407	1,407	1,407	1,407
6000 - Miscellaneous Agency	3,532	3,503	3,652	3,490	3,490	3,490	3,490	3,490
Total	**93,297**	**96,459**	**101,375**	**107,566**	**106,569**	**106,569**	**120,817**	**126,623**
Biennial Change				19,186		4,197		38,499
Biennial % Change				10		2		18
Governor's Change from Base								34,302
Governor's % Change from Base								16
Expenditures by Category								
Compensation	75,107	78,512	81,611	84,772	84,772	84,772	99,020	104,826
Operating Expenses	14,004	13,988	15,948	18,489	17,492	17,492	17,492	17,492
Grants, Aids and Subsidies	3,676	3,405	3,479	4,305	4,305	4,305	4,305	4,305
Capital Outlay-Real Property		31	1					
Other Financial Transaction	510	522	338					
Total	**93,297**	**96,459**	**101,375**	**107,566**	**106,569**	**106,569**	**120,817**	**126,623**
Full-Time Equivalents	**817.32**	**797.24**	**772.10**	**856.37**	**831.02**	**813.45**	**937.35**	**955.98**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		3,581		997				
Direct Appropriation	97,072	97,621	97,585	101,672	101,672	101,672	115,920	121,726
Transfers In			500					
Transfers Out	5,098	5,598	741					
Cancellations		3,386						
Balance Forward Out	3,374		997					
Expenditures	**88,600**	**92,218**	**96,347**	**102,669**	**101,672**	**101,672**	**115,920**	**121,726**
Biennial Change in Expenditures				18,197		4,328		38,630
Biennial % Change in Expenditures				10		2		19
Governor's Change from Base								34,302
Governor's % Change from Base								17
Full-Time Equivalents	817.32	797.24	772.10	856.37	831.02	813.45	937.35	955.98
4503 - Minnesota State Industries								
Balance Forward In	2,286	2,702	2,967	2,693	2,156	1,619	2,156	1,619
Receipts	1,502	875	1,102	870	870	870	870	870
Balance Forward Out	2,625	2,838	2,693	2,156	1,619	1,082	1,619	1,082
Expenditures	**1,164**	**738**	**1,376**	**1,407**	**1,407**	**1,407**	**1,407**	**1,407**
Biennial Change in Expenditures				881		31		31
Biennial % Change in Expenditures				46		1		1
Governor's Change from Base								0
Governor's % Change from Base								0
6000 - Miscellaneous Agency								
Balance Forward In	431	544	840	824	887	950	887	950
Receipts	3,645	3,778	3,637	3,553	3,553	3,553	3,553	3,553
Balance Forward Out	543	819	824	887	950	1,013	950	1,013
Expenditures	**3,532**	**3,503**	**3,652**	**3,490**	**3,490**	**3,490**	**3,490**	**3,490**
Biennial Change in Expenditures				107		(162)		(162)
Biennial % Change in Expenditures				2		(2)		(2)
Governor's Change from Base								0
Governor's % Change from Base								0

Program: Direct Care and Treatment
Activity: DCT Administration

https://mn.gov/dhs/people-we-serve/people-with-disabilities/services/direct-care-treatment/

AT A GLANCE

- Direct Care and Treatment (DCT) cares for 12,000 people annually at about 200 sites throughout Minnesota.
- DCT has more than 4,500 employees and an annual budget of more than $550 million.
- All-funds spending for DCT Administration was approximately $58 million for FY 2021. This represents 11 percent of the total DCT all-funds spending. Total DCT spending is less than 3 percent of overall spending for the Department of Human Services.

PURPOSE AND CONTEXT

Direct Care and Treatment (DCT) is a highly specialized behavioral health care system that serves people with mental illness, substance use disorders, intellectual disabilities, and other serious and often co-occurring conditions. DCT operates psychiatric hospitals and other inpatient mental health treatment facilities; inpatient substance abuse treatment facilities; special-care dental clinics; group homes and vocational sites; and the nation's largest treatment program for civilly committed sex offenders. The system cares for 12,000 patients and clients each year. Because these individuals have conditions that are complex and behaviors that can be challenging, other health care systems cannot or will not serve them. Some providers do not have the capacity; others do not have the expertise.

DCT programs and services are provided statewide, with most operating 24 hours a day, seven days a week. DCT Administration provides basic support for all service lines, including:

- Overseeing all fiscal and business processes
- Managing all operational functions
- Providing strategic direction, planning and implementation

ADMINISTRATIVE SUPPORT SERVICES PROVIDED

DCT Administration provides leadership and direction across the entire behavioral health system. It also works in collaboration with MNIT and DHS central office and has service-level agreements in place for additional support services such as IT, HR, Legislative, Communications, Legal, and other DHS-wide services. The cost for these additional support services are included in the overall $58 million budget for DCT Administration. DCT Administration support services include, but are not limited to:

- **Chief Quality Officer (CQO):** Responsible for managing relationships with several state and federal regulatory bodies that oversee DCT programs. The CQO works to ensure that staff understand regulatory requirements and that all standards are being followed. This department also aligns quality, safety, and security across each service line to ensure compliance.
- **Chief Compliance Officer (CCO):** Oversees risk assessment and contract management services that directly impact DCT operations. Through internal auditing and monitoring, the CCO ensures proper processes are in place and are followed.

- **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 accurate, timely, and up-to-date; records are properly stored; and staff access to a patient's private health information is appropriate and documented.
- **Learning and Development (L&D):** Provides ongoing training essential to the delivery of high-quality care. L&D ensures that DCT staff have the training they need to meet regulatory requirements and standards and to best serve patients and clients. Currently, 5 percent of all DCT staff time (a total of 450,000 hours) in any year is devoted to training to ensure compliance with regulatory standards and skill development.
- **Financial Management Office**: Provides DCT-specific fiscal services and manages the financial transactions and reporting to assure prudent use of public resources. Core functions 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 DCT's hospitals and clinics, financial reporting, and resident trust services for our institutional patients and clients.
- **DCT IT/MNIT Administrative Services:** Works in collaboration with MNIT to understand DCT's unique technological needs and to develop and implement an electronic health record system that provides access to each patient chart and gives clinical staff the ability to document every aspect of patient care to ensure compliance to care delivery, financial/billing, and expected clinical outcomes.
- **Health Equity Department:** Provides an integrated approach to ensure that all DCT staff have the education, skills, and tools they need to work effectively across DCT and have a positive impact on equity, diversity, and anti-racism.
- **Facilities Management (FM)**: Responsible for overseeing the care and maintenance of all DCT-owned and leased buildings, including maintaining a 10-year facility plan. FM also does all of the planning necessary to prepare DCT's capital budget requests. Core functions include leasing, design and management of construction projects, asset management, procurement, conditional facility assessment, department sustainability activities and strategic planning to meet the ongoing needs of DCT programs.
- **Office of Special Investigations (OSI):** Provides investigative services upon request that work in tandem with DCT-wide event reviews and root cause analyses. OSI works in collaboration with local law enforcement agencies when needed on patient-client elopements, deaths, drug and alcohol violations, assaults to staff or patients, and other events that require investigation.
- **Business Process Services:** Provides support to direct care staff on consistent and standardized business processes across all DCT programs and divisions for documenting admissions, assessments, treatment progress, discharge, etc. Another core function is to ensure these standardized business processes are incorporated into the DCT Behavioral Health Medical Record.

RESULTS

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	The number of new contracts executed [1]	302	215	FY20 & FY22
Quantity	The number of background checks completed for handgun permits [2]	12,154	12,371	FY20 & FY22
Quantity	The number of requests for releasing client specific information	10,521	13,391	FY20 & FY22
Quantity	The number of unique claims processed for client billings [3]	121,577	144,925	FY20 & FY22

[1] The number of new contracts with a start date in each fiscal year across DCT. Some contracts may have been formally executed or initiated in a different fiscal year. This measure does not include executed contract amendments or extensions.

[2] DCT HIMS staff complete the process as required under Minnesota Statutes section 245.041 to provide commitment information to local law enforcement agencies for the sole purpose of facilitating a firearms background check.

[3] The increase in claims in FY22 is primarily due to the reactivation of dental and vocational services that were suspended in FY20 due to the coronavirus pandemic.

Minnesota Statutes Chapter 246 (https://www.revisor.mn.gov/statutes/cite/246) provides the legal authority for Direct Care and Treatment State Operated Services.

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1000 - General	27,976	33,530	38,007	49,624	41,685	41,685	59,567	73,929
2000 - Restrict Misc Special Revenue	4,503	5,968	6,951	7,198	6,623	6,719	5,172	5,268
2001 - Other Misc Special Revenue	12,064	9,009	10,164	10,270	10,270	10,270	10,270	10,270
2403 - Gift	1							
3000 - Federal			273					
3010 - Coronavirus Relief	13,059	3,045						
6000 - Miscellaneous Agency	3							
Total	**57,605**	**51,552**	**55,395**	**67,092**	**58,578**	**58,674**	**75,009**	**89,467**
Biennial Change				13,330		(5,235)		41,989
Biennial % Change				12		(4)		34
Governor's Change from Base								47,224
Governor's % Change from Base								40
Expenditures by Category								
Compensation	37,317	30,646	32,127	38,543	35,574	35,670	45,486	49,142
Operating Expenses	19,391	19,962	22,625	28,549	23,004	23,004	29,523	40,325
Grants, Aids and Subsidies	5	0	1					
Capital Outlay-Real Property	278	356	15					
Other Financial Transaction	614	589	626					
Total	**57,605**	**51,552**	**55,395**	**67,092**	**58,578**	**58,674**	**75,009**	**89,467**
Total Agency Expenditures	57,605	51,552	55,395	67,092	58,578	58,674	75,009	89,467
Internal Billing Expenditures	114	20	14	141	141	141	141	141
Expenditures Less Internal Billing	**57,490**	**51,532**	**55,381**	**66,951**	**58,437**	**58,533**	**74,868**	**89,326**
Full-Time Equivalents	**226.23**	**226.99**	**269.28**	**291.66**	**259.94**	**255.29**	**324.59**	**338.56**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1000 - General								
Balance Forward In		4,348	16,029	3,110				
Direct Appropriation	47,398	63,686	53,424	63,243	58,414	58,414	76,296	90,658
Transfers In	4,909	9,909	12,932					
Transfers Out	20,113	25,613	41,268	16,729	16,729	16,729	16,729	16,729
Cancellations		2,771						
Balance Forward Out	4,218	16,029	3,110					
Expenditures	**27,976**	**33,530**	**38,007**	**49,624**	**41,685**	**41,685**	**59,567**	**73,929**
Biennial Change in Expenditures				26,125		(4,261)		45,865
Biennial % Change in Expenditures				42		(5)		52
Governor's Change from Base								50,126
Governor's % Change from Base								60
Full-Time Equivalents	188.59	189.02	230.41	251.50	219.78	215.13	284.43	298.40
2000 - Restrict Misc Special Revenue								
Balance Forward In	3,039	3,591	3,081	3,479	2,610	775	2,610	775
Receipts	5,028	4,938	4,848	6,329	4,788	6,720	3,337	5,269
Transfers In		500	2,500					
Transfers Out	2							
Balance Forward Out	3,563	3,060	3,478	2,610	775	776	775	776
Expenditures	**4,503**	**5,968**	**6,951**	**7,198**	**6,623**	**6,719**	**5,172**	**5,268**
Biennial Change in Expenditures				3,678		(807)		(3,709)
Biennial % Change in Expenditures				35		(6)		(26)
Governor's Change from Base								(2,902)
Governor's % Change from Base								(22)
Full-Time Equivalents	37.64	37.97	38.87	40.16	40.16	40.16	40.16	40.16
2001 - Other Misc Special Revenue								
Balance Forward In	1,739	369	345	367	369	370	369	370
Receipts	298	1,486	10,186	10,272	10,271	10,271	10,271	10,271
Transfers In	10,395	7,500						
Balance Forward Out	369	345	367	369	370	371	370	371
Expenditures	**12,064**	**9,009**	**10,164**	**10,270**	**10,270**	**10,270**	**10,270**	**10,270**
Biennial Change in Expenditures				(639)		106		106

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Biennial % Change in Expenditures				(3)		1		1
Governor's Change from Base								0
Governor's % Change from Base								0

2400 - Endowment

Balance Forward In	64	65	65	65	66	67	66	67
Receipts	1	0	0	1	1	1	1	1
Balance Forward Out	65	65	65	66	67	68	67	68

2403 - Gift

Balance Forward In	8	10	10	11	11	11	11	11
Receipts	2	0	1					
Transfers In		8						
Transfers Out		8						
Balance Forward Out	10	10	11	11	11	11	11	11
Expenditures	**1**							
Biennial Change in Expenditures				(1)		0		0
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								

3000 - Federal

Balance Forward In		650						
Receipts	650	7,202	273					
Balance Forward Out	650	7,852						
Expenditures			**273**					
Biennial Change in Expenditures				273		(273)		(273)
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								

3010 - Coronavirus Relief

Direct Appropriation	13,059	3,045						

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures	**13,059**	**3,045**						
Biennial Change in Expenditures				(16,104)		0		0
Biennial % Change in Expenditures				(100)				
Governor's Change from Base								0
Governor's % Change from Base								

4100 - SOS TBI & Adol Ent Svcs

Balance Forward In	116	118	119	119	120	121	120	121
Receipts	2	1	0	1	1	1	1	1
Balance Forward Out	118	119	119	120	121	122	121	122

6000 - Miscellaneous Agency

Balance Forward In	177	180	181	182	183	184	183	184
Receipts	3	1	1	1	1	1	1	1
Balance Forward Out	178	181	182	183	184	185	184	185
Expenditures	**3**							
Biennial Change in Expenditures				(3)		0		0
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								

Program: Fiduciary Activities
Activity: Fiduciary Activities

http://mn.gov/dhs/people-we-serve/children-and-families/services/child-support/

AT A GLANCE

- All funds spending for Fiduciary Activities was $597 million in state fiscal year 2021.
- Child Support program payments are the bulk of this activity.

PURPOSE AND 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:
  - 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 by Federal Fiscal Year (FFY)

State	*Due 2020 in Millions ($)*	*Paid 2020 in Millions ($)*	*FFY 2020 (%)*	*FFY 2018 (%)*	*FFY 2017 (%)*	*FFY 2016 (%)*
Pennsylvania	1,211	1,005	83.0	84.2	84.1	84.3
North Dakota	110	84	76.2	75.3	73.2	72.7
Vermont	43	32	75.7	74.6	73.8	74.2
Minnesota	**562**	**424**	**75.4**	**74.9**	**74.5**	**74.2**
Wisconsin	697	516	74.1	74.7	74.6	74.4

State Performance on Obligations in Arrears

State	*FFY 2020 (%)*	*Cases with Arrears (2020)*	*Cases with Payment Towards Arrears (2020)*	*FFY 2019 (%)*	*FFY 2018 (%)*
Pennsylvania	88.0	235,998	207,837	84.8	84.3
Vermont	82.5	11,569	9,544	77.7	76.2
Indiana	79.8	208,385	166,292	73.5	72.4
Minnesota	**79.7**	**156,472**	**124,632**	**72.9**	**72.5**
Michigan	79.1	503,323	398,293	65.8	66.0

Source: 2021 Minnesota Child Support Performance Report (https://www.lrl.mn.gov/docs/2022/other/220351.pdf)

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)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
2000 - Restrict Misc Special Revenue	2,295							
6000 - Miscellaneous Agency	11,726	7,363	5,804	209,672	209,672	209,672	209,672	209,672
6003 - Child Support Enforcement	615,778	589,719	549,644	641,955	641,955	641,955	641,955	641,955
Total	**629,799**	**597,082**	**555,448**	**851,627**	**851,627**	**851,627**	**851,627**	**851,627**
Biennial Change				180,194		296,179		296,179
Biennial % Change				15		21		21
Governor's Change from Base								0
Governor's % Change from Base								0
Expenditures by Category								
Compensation	90	107	128	7	7	7	7	7
Operating Expenses	5,305	3,228	1,957	3,650	3,650	3,650	3,650	3,650
Grants, Aids and Subsidies	1,537	515	747	194,260	194,260	194,260	194,260	194,260
Other Financial Transaction	622,867	593,232	552,615	653,710	653,710	653,710	653,710	653,710
Total	**629,799**	**597,082**	**555,448**	**851,627**	**851,627**	**851,627**	**851,627**	**851,627**
Full-Time Equivalents	**1.16**	**0.69**	**0.55**	**0.55**	**0.06**	**0.06**	**0.06**	**0.06**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
2000 - Restrict Misc Special Revenue								
Balance Forward In	3,831	3,444	1,853	598				
Receipts	3,317	3,173	1,958	4,296	2,927	4,179	2,927	4,179
Transfers In	199	34	1,499		1,967	715	1,967	715
Transfers Out	1,747	4,798	4,712	4,894	4,894	4,894	4,894	4,894
Balance Forward Out	3,303	1,853	598					
Expenditures	**2,295**							
Biennial Change in Expenditures				(2,295)		0		0
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								
6000 - Miscellaneous Agency								
Balance Forward In	3,736	3,669	4,669	5,995	5,996	5,997	5,996	5,997
Receipts	11,377	8,158	7,130	209,673	209,673	209,673	209,673	209,673
Transfers Out		0						
Balance Forward Out	3,387	4,464	5,995	5,996	5,997	5,998	5,997	5,998
Expenditures	**11,726**	**7,363**	**5,804**	**209,672**	**209,672**	**209,672**	**209,672**	**209,672**
Biennial Change in Expenditures				196,387		203,868		203,868
Biennial % Change in Expenditures				1,029		95		95
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents	1.16	0.69	0.55	0.55	0.06	0.06	0.06	0.06
6003 - Child Support Enforcement								
Balance Forward In	9,695	20,037	12,104	9,586	17,726	25,866	17,726	25,866
Receipts	626,121	581,786	547,126	650,095	650,095	650,095	650,095	650,095
Balance Forward Out	20,037	12,104	9,586	17,726	25,866	34,006	25,866	34,006
Expenditures	**615,778**	**589,719**	**549,644**	**641,955**	**641,955**	**641,955**	**641,955**	**641,955**
Biennial Change in Expenditures				(13,898)		92,311		92,311
Biennial % Change in Expenditures				(1)		8		8
Governor's Change from Base								0
Governor's % Change from Base								0

Program: Technical Activities
Activity: Technical Activities

AT A GLANCE

- All funds spending for Technical Activities was $776 million during state fiscal year 2021.
- Technical Activities largely consists of federal administrative earned by and paid to counties, tribes, and other state and local agencies.

PURPOSE AND 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.	98.4%	98.6%	FY2019 to FY2020

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)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Expenditures by Fund								
1200 - State Government Special Rev	22	15	27					
2000 - Restrict Misc Special Revenue	836	747	1,314	957	927	927	927	927
2001 - Other Misc Special Revenue	10,695	1,608	15,134	6,302	6,174	6,174	6,174	6,174
2005 - Opiate Epidemic Response			1					
2360 - Health Care Access	177	122	219	219	219	219	219	219
3000 - Federal	662,758	692,155	681,408	828,382	822,035	822,024	822,035	822,024
3001 - Federal TANF	71,659	81,344	77,495	78,260	71,493	71,493	71,493	71,493
4800 - Lottery	1	0	1					
Total	**746,147**	**775,992**	**775,597**	**914,120**	**900,848**	**900,837**	**900,848**	**900,837**
Biennial Change				167,578		111,968		111,968
Biennial % Change				11		7		7
Governor's Change from Base								0
Governor's % Change from Base								0
Expenditures by Category								
Compensation				770	37	37	37	37
Operating Expenses	292,375	297,242	292,744	400,462	394,951	394,943	394,951	394,943
Grants, Aids and Subsidies	443,754	478,749	469,997	507,888	500,860	500,857	500,860	500,857
Other Financial Transaction	10,019		12,856	5,000	5,000	5,000	5,000	5,000
Total	**746,147**	**775,992**	**775,597**	**914,120**	**900,848**	**900,837**	**900,848**	**900,837**
Total Agency Expenditures	746,147	775,992	775,597	914,120	900,848	900,837	900,848	900,837
Internal Billing Expenditures	68,094	36,620	66,430	90,255	86,420	86,422	86,420	86,422
Expenditures Less Internal Billing	**678,053**	**739,371**	**709,168**	**823,865**	**814,428**	**814,415**	**814,428**	**814,415**
Full-Time Equivalents				**0.86**	**0.10**	**0.09**	**0.10**	**0.09**

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
1200 - State Government Special Rev								
Open Appropriation	22	15	27					
Expenditures	**22**	**15**	**27**					
Biennial Change in Expenditures				(11)		(27)		(27)
Biennial % Change in Expenditures				(29)				
Governor's Change from Base								0
Governor's % Change from Base								
2000 - Restrict Misc Special Revenue								
Balance Forward In	97	151	105	144	114	114	114	114
Receipts	89	19	97	162	162	162	162	162
Transfers In	788	712	1,913	765	765	765	765	765
Transfers Out	7	30	657					
Balance Forward Out	132	105	144	114	114	114	114	114
Expenditures	**836**	**747**	**1,314**	**957**	**927**	**927**	**927**	**927**
Biennial Change in Expenditures				688		(417)		(417)
Biennial % Change in Expenditures				43		(18)		(18)
Governor's Change from Base								0
Governor's % Change from Base								0
2001 - Other Misc Special Revenue								
Balance Forward In	666	579	910	135	2,345	4,555	2,345	4,555
Receipts	1,127	1,240	1,764	8,042	7,914	7,914	7,914	7,914
Transfers In	9,297	1,306	12,595	470	470	470	470	470
Transfers Out		1,501						
Balance Forward Out	395	15	135	2,345	4,555	6,765	4,555	6,765
Expenditures	**10,695**	**1,608**	**15,134**	**6,302**	**6,174**	**6,174**	**6,174**	**6,174**
Biennial Change in Expenditures				9,132		(9,088)		(9,088)
Biennial % Change in Expenditures				74		(42)		(42)
Governor's Change from Base								0
Governor's % Change from Base								0
2005 - Opiate Epidemic Response								
Direct Appropriation		5,439						

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Open Appropriation			1					
Transfers Out		5,439						
Expenditures			**1**					
Biennial Change in Expenditures				1		(1)		(1)
Biennial % Change in Expenditures								
Governor's Change from Base								0
Governor's % Change from Base								

2360 - Health Care Access

Open Appropriation	177	122	219	219	219	219	219	219
Expenditures	**177**	**122**	**219**	**219**	**219**	**219**	**219**	**219**
Biennial Change in Expenditures				140		0		0
Biennial % Change in Expenditures				47		0		0
Governor's Change from Base								0
Governor's % Change from Base								0

3000 - Federal

Balance Forward In	311	3,914	6	87	87	87	87	87
Receipts	662,452	688,246	681,505	828,382	822,035	822,024	822,035	822,024
Transfers Out			16					
Balance Forward Out	5	5	87	87	87	87	87	87
Expenditures	**662,758**	**692,155**	**681,408**	**828,382**	**822,035**	**822,024**	**822,035**	**822,024**
Biennial Change in Expenditures				154,877		134,269		134,269
Biennial % Change in Expenditures				11		9		9
Governor's Change from Base								0
Governor's % Change from Base								0
Full-Time Equivalents				0.86	0.10	0.09	0.10	0.09

3001 - Federal TANF

Balance Forward In	6,321							
Receipts	65,338	81,344	77,495	78,260	71,493	71,493	71,493	71,493
Expenditures	**71,659**	**81,344**	**77,495**	**78,260**	**71,493**	**71,493**	**71,493**	**71,493**
Biennial Change in Expenditures				2,752		(12,769)		(12,769)

(Dollars in Thousands)

	Actual FY20	Actual FY21	Actual FY22	Estimate FY23	Forecast Base FY24	Forecast Base FY25	Governor's Recommendation FY24	Governor's Recommendation FY25
Biennial % Change in Expenditures				2		(8)		(8)
Governor's Change from Base								0
Governor's % Change from Base								0

3010 - Coronavirus Relief

Balance Forward In		50						
Direct Appropriation	50	1						
Transfers Out		50						
Cancellations		1						
Balance Forward Out	50							

4800 - Lottery

Open Appropriation	1	0	1					
Expenditures	**1**	**0**	**1**					
Biennial Change in Expenditures				0		(1)		(1)
Biennial % Change in Expenditures				(38)				
Governor's Change from Base								0
Governor's % Change from Base								

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HUD 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.	$ 2,179	$ 3,500	$ 3,500	$ 3,500	Yes	1.00
HHS 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.	$ 54,907	$ 78,617	$ 80,924	$ 82,584	Yes	-
HHS 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.	$ 2,848	$ 2,848	$ 2,848	$ 2,848	No	3.20

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
USDA 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 contracts with the University of Minnesota Extension, 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.	$ 13,051	$ 12,980	$ 12,980	$ 12,980	Yes	2.60
DOE 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.	$ 105	$ 90	$ 90	$ 90	No	0.50
USDA 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.	$ -	$ -	$ -	$ -	No	-
HHS 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.	$ 5,443	$ 8,523	$ 8,523	$ 8,523	No	-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 93.324	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.	$ 877	$ 880	$ 910	$ 910	No	2.90
HHS 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.	$ 4,128	$ 4,221	$ 4,221	$ 4,221	No	35.50
USDA 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.	$ 1,833	$ 2,840	$ 2,840	$ 2,840	Yes	1.90
HHS 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.	$ 10,563	$ 8,768	$ 8,737	$ 8,737	Yes	21.00
USDA 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).	$ 71,440	$ 76,122	$ 64,847	$ 78,422	Yes	-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 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.	$ 4,949	$ 8,531	$ 15,958	$ 18,958	No	8.00
HHS 93.959	Block Grants for Prevention and Treatment of Substance Abuse (SABG): The Behavioral Health fund 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 Behavioral Health fund 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.	$ 23,677	$ 41,888	$ 41,888	$ 41,888	Yes	19.87

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 93.575 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 32,000 attendees through Child Care Resource & Referral agencies.	$ 133,581	$ 215,811	$ 319,943	$ 319,943	Yes	33.90
HHS 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)	$ 15,657	$ 7,648	$ 4,720	$ 4,720	Yes	-
HHS 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.	$ 5	$ 108	$ 100	$ 100	No	1.00

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 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 about 183 participants annually.	$ 223	$ 396	$ 396	$ 396	No	1.00
HHS 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.	$ 115,776	$ 140,000	$ 139,900	$ 139,900	Yes	-
USDA 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.	$ 4,981	$ 15,400	$ 15,400	$ 15,400	Yes	-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 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.	$ 13,367	$ 25,938	$ 28,365	$ 28,365	No	0.00
HHS 93.048	Special Programs for the Aging (MN Medical 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.	$ 293	$ 491	$ 635	$ 635	No	0.55
HHS 93.048	Innovations in Nutrition Programs. This grant would support the development of innovative and promising practices in the Older Americans Act Senior Nutrition Programs in multiple communities around the state.	$ -	$ -	$ -	$ -	No	-
HHS 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.	$ 853	$ 1,638	$ 1,638	$ 1,638	Yes	0.30
USDA 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.	$ 1,314,570	$ 1,609,497	$ 1,609,497	$ 1,609,497	No	-
HHS 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 Activities 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.	$ 3,092	$ 3,364	$ 3,349	$ 3,349	Yes	-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 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.	$ 11,654	$ 13,794	$ 14,000	$ 14,000	No	2.90
HHS 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.	$ 5,988	$ 8,582	$ 8,582	$ 8,582	No	-
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.	$ 3,219	$ 4,436	$ 4,436	$ 4,436	Yes	2.80

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
10.561	State Administrative Matching Funds for the Supplemental Nutrition Assistance Program: Federal funds for state and county costs related to employment and training for Supplemental Nutrition Assistance Program (SNAP) recipients.	$ 2,294	$ 5,055	$ 5,055	$ 5,055	No	2.00
HHS 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.	$ 71,321	$ 51,696	$ 61,698	$ 74,459	Yes	-
HHS 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.	$ 2,344	$ 1,737	$ 1,735	$ 1,735	Yes	-
HHS 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.	$ 1,844	$ 1,242	$ 1,121	$ 1,121	No	0.70
HHS 93.761	Evidenced Based Falls Prevention Programs Financed Solely 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.		$ -	$ -	$ -	No	-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 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.	$ 2,890	$ 6,850	$ 8,011	$ 8,011	Yes	-
HHS 93.597	Grants to States for Access & Visitation Programs: Grant provides resources 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.	$ 154	$ 170	$ 170	$ 170	No	-
HHS 93.778	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.	$ 10,853,179	$ 12,372,224	$ 11,024,129	$ 10,992,699	No	-
HHS 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.	$ 215	$ 288	$ 280	$ 280	No	2.60

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 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.	$ 10,679	$ 28,904	$ 25,632	$ 25,632	Yes	19.42
HHS 93.767	Medical Assistance Program: 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.	$ 80,503	$ 76,610	$ 78,129	$ 73,534	No	-
USDA 10.551	Supplemental Nutrition Assistance Program (SNAP): Grant benefits cash out provided to SSI and elderly recipients.	$ 62,582	$ 70,000	$ 70,000	$ 70,000	No	-
HHS 93.556	Promoting Safe and Stable Families (Title 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.	$ 3,913	$ 4,337	$ 4,337	$ 4,337	No	3.60

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 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.	$ 424,502	$ 628,634	$ 628,649	$ 628,649	No	-
HHS 93.667	Social Service Block Grant (Title XX): 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/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, 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.	$ 31,663	$ 41,012	$ 41,012	$ 41,012	No	11.70
HHS 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	$ 637	$ 818	$ 445	$ 445	Yes	0.00
HHS 93.590	Community-Based Child Abuse Prevention (CBCAP) Grants	$ 2,176	$ 4,271	$ 4,271	$ 4,271		
HHS 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.	$ 2,816	$ 5,942	$ 5,942	$ 5,942	No	-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 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.	$ 1,311	$ 2,000	$ 2,000	$ 2,000	Yes	-
USDA 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.	$ 3,324	$ 4,291	$ 4,291	$ 4,291	No	2.00
HHS 93.071	Special Programs for the Aging: (Priority 1 SHIP).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.	$ 395	$ 453	$ 308	$ 308	No	-
HHS 93.071	Affordable Care Act, Medicare Improvements for Patients and Providers (MIPPA) Priority 2. ACL grants to AAA's to increase capacity to provide information and assistance regarding Medicare.	$ 289	$ 280	$ 262	$ 262	No	0.00
HHS 93.071	Affordable Care Act, Medicare Improvements for Patients and Providers (MIPPA) Priority 3. ACL grants to ADRC's to increase capacity to provide information and assistance regarding Medicare.	$ 103	$ 99	$ 91	$ 91	No	-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 93.778	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.	$ 4,128	$ 7,000	$ 7,000	$ 7,000	No	-
HHS 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. 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.	$ 17,478	$ 25,474	$ 29,619	$ 34,227	Yes	9.00
HHS 93.778	Federal Basic Health Funding: The MinnesotaCare program is currently operating as a federal basic health plan (BHP) under section 1331 of the Affordable Care Act. Under the BHPHS currently receives 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.	$ 575,387	$ 614,208	$ 550,114	$ 557,588	No	-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 93.090	Title VI-E Guardianship Assistance - 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.	$ 16,480	$ 13,708	$ 13,539	$ 14,587	Yes	-
HHS 93.243	Strategic Prevention Framework for Prescription Drugs (SPF-Rx): 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, 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. This grant has now expired.	$ 13	$ -	$ -	$ -	No	0.50
HHS 93.104	Systems of Care Grant: 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. This grant ended September 29, 2022.	$ 3,150	$ 1,117	$ -	$ -	Yes	6.00

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 93.243	Medication-Assisted Treatment (MAT): Build on the comprehensive Minnesota State Targeted Response to the Opioid Crisis (MN Opioid STR) through this Minnesota Targeted Capacity Expansion of Medication Assisted Treatment Services to target under-served African-American and American Indian high-need communities not reached through MN Opioid State Targeted Response grants. This grant has expired as of September 2021.	$ 242	$ -	$ -	$ -	No	1.00
HHS 93.234	TBI Demo Grant: Grant funds will be used to improve Minnesota's TBI system to better support person centered approaches and maximize the independence, well-being and health of people with TBIs and their families. The objectives are to: 1) expand the MN Trauma registry system to collect and analyze data that directly supports policy and services for Minnesotans with a TBI and their families; 2) establish a statewide and cross-agency plan for TBI; 3) increase education and supports for Native Americans living with TBIs; and 4) streamline access to person centered supports resulting in informed choice.	$ 2	$ 144	$ 144	$ 144	Yes	1.00
HHS 93.788	State Opioid Response (SOR): Expedite opioid treatment and recovery resources and support integration of services at each point in the substance use disorder service continuum through a comprehensive effort to provide targeted response for the following populations: American Indian; African American; and populations with justice involvement. This grant expired September 30, 2021.	$ 1,473	$ -	$ -	$ -	No	8.70
HHS 93.243	Pregnant and Postpartum Women (PPW): Expand and enhance women's pregnant and postpartum substance use disorder (SUD) services across our continuum of care (prevention, treatment and recovery) for women, children and families who receive treatment for SUDs. The program will serve 100 women and 200 children per grant year.	$ 505	$ 1,093	$ 637	$ -	Yes	1.00

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 93.747	Grants to Enhance State Adult Protective Services. This grant designs and builds development and quality assurance environments to mirror the state's person-centered adult protection data warehouse, add customized reporting for structured tool data, evaluate tool reliability and identify factors impacting report intake outcomes. The intended goal is to improve data quality, increase case level reporting capacity to Administration for Community Living and improve consistency in adult protection assessment and screening response for vulnerable adults. Products for this grant will include creation of quality assurance and development environments for the state's person-centered adult protection data warehouse for improved quality of NAMRS case level reporting.	$ 27	$ 405	$ 379	$ 379	Yes	2.00
USDA 10.568	Trade Mitigation Program. To help supplement the diets of low-income persons by making funds available to States for storage and distribution costs incurred by The Emergency Food Assistance Program (TEFAP) State agencies and local organizations, such as soup kitchens, food banks, and food pantries, including faith-based organizations, in providing food assistance to needy persons.	$ -	$ 759	$ 759	$ 759	No	-
HHS 93.788	State Opioid Response (SOR) Supplemental – Supplemental funds through SAMSHA State Opioid Response (SOR) grant to expand Medication Assisted Treatment, improving recovery resources for Medication Assisted treatment, increasing opioid use disorder workforce and expanding opioid use disorder training and response with Naloxone. Target populations include rural and disparate populations specifically including African Americans, American Indians. This grant expired September 30, 2021.	$ 822	$ -	$ -	$ -	No	-
HHS 93.564	Digital Marketing Grant: Grant to increase participation in the Child Support Program	$ 100	$ 100	$ 50	$ -	No	-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 93.045C	Special Programs for the Aging: (Home Delivered Meals) FFCRA OAA grants to AAAs and service providers to provide home delivered meal services targeted to seniors in the greatest economic and social need in response to the pandemic. OAA grants to AAAs for administrative purpose and awards to direct service providers. The grant includes administrative funding to administer and implement the grant.	$ 144	$ -	$ -	$ -	Yes	-
HUD 14.231	Emergency Solutions Grant CARES: 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.	$ 4,480	$ 1,222	$ 1,222	$ -	No	-
HHS 93.044C	Special Programs for the Aging (Aging Supportive Services): CARES OAA grants to AAAs and local providers to provide a variety of community-based supportive services in response to the pandemic. OAA grants to AAAs for administrative purpose and awards to direct service providers. The grant includes administrative funding to administer and implement the grant and also for the provision of direct procurement by the SUA.	$ 357	$ 570	$ -	$ -	Yes	-
HHS 93.045	CARES Act for Nutrition Services under Title III-C of the Older Americans Act. This is a supplemental award from Administration for Community Living (ACL) to provide Nutrition Services to low-income older adults who depend on services to help them shelter in place in response to the Coronavirus pandemic.	$ 254	$ 673	$ -	$ -	Yes	0.20
HHS 93.052C	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 This grant includes administrative funding to administer and implement the grant and also for the provision of direct procurement by the SUA.	$ 166	$ 26	$ -	$ -	Yes	-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 93.042C	Special Programs for the Aging (Ombudsman Supplement): This CARES OAA grant provides additional support for the Ombudsman for Long Term Care office in response to the pandemic. 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.	$ 181	$ 88	$ 88	$ 88	No	2.60
HHS 92.048C	Aging and Disability Resource Center/No Wrong Door System Funding Opportunity: Critical Relief Funds for COVID-19 Pandemic Response. The purpose of the emergency funds is to support capacity and resource allocation at the state and local level to ensure coordination across agencies and support immediate response to urgent needs resulting from COVID-19. Funding will enable Minnesota's Aging and Disability Resource Center (Senior LinkAge Line and Disability HUB) in providing critical access functions to serve populations most at risk of COVID-19 and mitigate adverse effects resulting from this national pandemic.	$ 147	$ 498	$ -	$ -	No	1.00
HHS 93.575	Child Care Development Block Grant (CCDBG) CARES Act: These funds are to prevent, prepare for, and respond to COVID-19.	$ 14,421	$ 5,000	$ 5,000	$ -	No	-
HHS 93.569	Community Services Block Grant (CSBG) CARES: 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.	$ 6,710	$ 2,217	$ -	$ -	No	-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 93.569	CSBG Discretionary CARESC19: Community Services Block Grant (CSBG) Discretionary: 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.	$ 498	$ -	$ -	$ -		-
HHS 93.556	Family First Transition Act	$ 138	$ 4,930	$ 5,160	$ 4,910	No	-
HUD 14.231	Emergency Solutions Grants. These funds are to be used to prevent, prepare for, and respond to the coronavirus pandemic among individuals and families who are homeless or receiving homeless assistance and to support additional homeless assistance and prevention activities to mitigate the impacts of COVID-19.	$ 10,980	$ 3,644	$ 2,600	$ -	No	-
HHS 93.564	Responsible Parenting Grant: Grant to develop and implement a child support curriculum for incarcerated youth and young adults to improve preparation for parenthood.	$ 326	$ 600	$ 650	$ 650	No	-
HHS 93.788	State Opioid Response (SOR) Grant. This grant is to expedite opioid treatment and recovery resources and support integration of services at each point in the substance use disorder service continuum.	$ 15,600	$ 14,588	$ 7,497	$ -	No	-
HHS 97.032	Crisis Counseling Regular Services Program (RSP). This fund is a continuation of the Immediate Services Program fund received to provide crisis counseling services to those affected by COVID-19. These funds will be used to contract with 11 community-based organizations for outreach, crisis counseling and referral services, and short-term intervention counseling for mental health problems caused or aggravated by the COVID-19 disaster. This grant has expired.	$ 378	$ -	$ -	$ -	No	-
HHS 93.982	Disaster Response Grant	$ 762	$ -	$ -	$ -		-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 93.575	Child Care and Development Block Grant (Consolidated Appropriations Act): 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.	$ 25,461	$ 11,584	$ 13,000	$ -		-
USDA 10.561	State Administrative Matching Funds for the Supplemental Nutrition Assistance Program: Federal funds for State Supplemental Nutrition Assistance Program (SNAP) for administrative costs related to Pandemic-EBT and other COVID related expense. This funding is 100% federal funding.	$ 5,097	$ 8,386	$ -	$ -	No	13.00
HHS 93.583	DHS Refugee Entrant Assistance Coordination Program authorized under 412 (e) (7) of the Immigration and Nationality Act. 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 TANF-eligible and within three years of arriving in this country or grant of asylum to be eligible for services under these grants.	$ 190	$ 1,500	$ 1,800	$ 1,800	No	0.50
USDA 10.561	Supplemental Nutrition Assistance Program (SNAP) (H552051 - 12 SNAP CAA 100% Mass Change Adm and H552052 - 91 SNAP CAA 100% Mass Change Ind)	$ 40	$ -	$ -	$ -		-
HHS 93.045C	Special Programs for the Aging: (Home Delivered Meals) CARES OAA grants to AAAs and service providers to provide home delivered meal services targeted to seniors in the greatest economic and social need in response to the pandemic. OAA grants to AAAs for administrative purpose and awards to direct service providers. The grant includes administrative funding to administer and implement the grant and also for the provision of direct procurement by the SUA.	$ 2,490	$ 806	$ 806	$ -	Yes	-
HHS 93.747C	CRRSA and ARP LTC Ombudsman SSA - Funds under this plan will support the Office of the Long-Term Care Ombudsman.	$ 19	$ 342	$ -	$ -		-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 93.747C	CRRSA AdultProtectiveSvcs SSA Funds expended from the Coronavirus Response and Relief Supplemental Appropriations Act, 2021 are to be spent in accordance with Elder Justice Act Section 2042(b) for Adult Protective Services programs at the state and local level to respond to the Coronavirus Emergency. Funds awarded under this opportunity will provide Adult Protective Services programs (APS) in the States and territories with resources related to their response during the Coronavirus Public Health Emergency. APS programs must expend funds on allowable activities as defined by the Elder Justice Act and State and local policy. This funding is intended to enhance, improve, and expand the ability of APS to investigate allegations of abuse, neglect, and exploitation in the context of COVID-19 and to respond to the needs of adults experiencing such abuse, neglect and exploitation.	$ 671	$ 1,240	$ 566	$ 280		-
USDA 10.561	SNAP 100% Admin ARP - funds are used to reimburse states for the administration of the SNAP program. (American Rescue Plan Act)	$ 3,377	$ 4,853	$ 4,853	$ 4,853		-
HHS 93.665	Emergency Response to COVID-19, Substance Abuse and Mental Health Services Administration (SAMHSA): The Department of Human Services, partnering with our existing Certified Community Behavioral Health Clinics (CCBHCs), will provide mental health, substance use disorder and co-occurring treatment services to people who have been impacted by COVID-19. Grant funds will help Minnesota serve people with serious mental illness (SMI), substance use disorders (SUD) and co-occurring disorders, including healthcare practitioners, other first responders and individuals and families experiencing mental health concerns less severe than SMI. The state estimates 6,600 people will be served through this funding; 70% of which will be SMI/SUD, 20% healthcare practitioners and first responders, and 10% people with mental health concerns less than SMI.	$ 2,983	$ 2,192	$ -	$ -	No	0.70

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 93.674C	Independent Living Grants CAA to assist current and former foster care youth in achieve self-sufficiency.	$ 2,314	$ 4,429	$ 1,400	$ 1,400		-
HHS 93.044C	CAA-CDC-OAA Vaccine Access - The grant is issued in order for the grantee and the Area Agencies on Aging in its jurisdiction to serve older adults for the following purposes: (1) Disseminating credible information about COVID-19 vaccines and help direct those with questions to additional sources of information (2) Identifying people who may need help getting a COVID-19 vaccination, including those who are unable to independently travel to a vaccination site (3) Helping with scheduling a COVID-19 vaccination appointment for those who need help (4) Arranging or providing accessible transportation to COVID-19 vaccination sites (5) Providing technical assistance to local health departments and other entities on vaccine accessibility (6) Providing personal support if needed (e.g., peer support), and (7) Reminding the person of their second vaccination appointment if needed.	$ 714	$ 90	$ -	$ -		
HHS 93.052	ARP OAA Family Caregiver 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 Activities 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.	$ 702	$ 1,589	$ 595	$ 595		-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 93.042	Special Programs for the Aging - Long Term Care Ombudsman: The principal role of this Ombudsman Program is to investigate and resolve complaints made by or on behalf of residents of nursing homes or other long-term care facilities. Ombudsmen 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.	$ 4	$ 83	$ 75	$ 75	No	0.00
HHS 93.044	ARP OAA Supportive Services 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.	$ 2,273	$ 5,112	$ 1,830	$ 1,826		
HHS 93.045	Congregate Meals and Home Delivered Meals (Consolidated Appropriations Act): Provide grants to states to support nutrition services including nutritious meals, nutrition education and other appropriate nutrition services for older Americans in order to maintain health, independence and quality of life.	$ 1,059	$ 3,905	$ 1,190	$ 1,190	No	-
HHS 93.045C	American Rescue Plan (ARP) for Home Delivered Meals under Title III-C2 of OAA American Rescue Plan Act: Home Delivered Meals American Rescue Act for Nutrition Services under Title III-C of the Older Americans Act. This is a supplemental award from Administration for Community Living (ACL) to provide Nutrition Services to low-income older adults who depend on services to help them shelter in place in response to the Coronavirus pandemic.	$ 2,315	$ 2,379	$ 4,838	$ 4,838		-
HHS 93.043	ARP OAA Preventative Health OAA grants to AAAs and service providers to provide preventive health information and services to seniors. The adjusted spending authority reflects an anticipated increase in the base award effective Oct. 1, 2022.	$ 217	$ 362	$ 533	$ 533		-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 93.575	ARP CCDBG Stabilization - n additional allocation to CCDBG through the 2021 American Rescue Plan Act. CCDBG provides funds to States to increase the availability, affordability, and quality of child care services for low-income families. The goal of the child care stabilization grants is to provide financial relief to child care providers to help defray unexpected business costs associated with the pandemic, and to help stabilize their operations so that they may continue to provide care.	$ 163,285	$ 160,604	$ 81,129	$ -		-
USDA 10.568	TEFAP Farms to Food Bank Grant - Funds are utilized to engage Minnesota farmers, growers, distributors and processors as food donors; and to assist them to harvest, process, and package and transport these food donations to help relieve hunger in the state.	$ 217	$ 200	$ 200	$ 200		-
FEMA 97.036	FEMA-Supplemental Staff-Proj 175368: FEMA Funding for Emergency Protective Measures-Provided Short Term Emergency Staffing for staff shortage due to COVID-19 for State facilities supporting behavioral needs, the disabled, the homeless, and the elderly, jurisdiction wide, at State of Minnesota from 10/23/2020 to 12/31/2020.	$ 429	$ -	$ -	$ -		-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 93.575 93.596	ARP CCDBG Discretionary - An additional allocation to CCDBG through the 2021 American Rescue Plan Act. CCDBG 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. This includes $16 million of ARP funds that were unallocated during the 2021 legislative session.	$ 28,575	$ 83,005	$ 157,043	$ 229,866		-
USDA 10.537	SNAP Data Grant: MN SNAP E&T Data Grant: Outcomes and Equity Project.	$ 374	$ 624	$ 624	$ 624		-
HHS 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.	$ 24	$ 2,172	$ 2,172	$ 2,172	No	1.40

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 93.669	ARPA Child Abuse Grant - This program provides funds for States to improve their child protective service systems. This program assists states in improving intake, assessment, screening, and investigation of child abuse and neglect reports; Risk and safety assessment protocols; Training for child protective services workers and mandated reporters; Programs and procedures for the identification, prevention, and treatment of child abuse and neglect; Development and implementation of procedures for collaboration among child protection services, domestic violence, and other agencies; and services to disabled infants with life-threatening conditions and their families	$ 24	$ 825	$ 825	$ 825		-
HHS 93.564	Responsible Parenting Grant - This grant is develops programs that educate teens and young adults about the financial, legal, and emotional responsibilities of parenthood. DHS will focus on educating indigenous teens and young adults, resulting in a curriculum that can be shared with other tribal nations and organizations across the United States through the grant's cohort model.	$ -	$ 700	$ 600	$ 600		-
HHS 93.959	Substance Abuse Prevention and Treatment Block Grant (Consolidated Appropriations Act): To provide financial assistance to states and territories to support projects for the development and implementation of prevention, treatment and rehabilitation activities directed to the diseases of alcohol and drug abuse. (NOTE- we have a No cost extension request into SAMHSA-- putting some funds in FY 24 in case it gets approved- the total grant is $22.591 million).	$ 782	$ 12,264	$ 20,000	$ -	Yes	19.00
HHS 93.048C	MN Aging and Disability Resource Center - OAA Response to COVID-19 Pandemic to meet a variety of emergency needs of older adults and individuals of all ages with disabilities.	$ 59	$ 385	$ -	$ -		-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 93.959	Substance Abuse Block Grant-American Rescue Plan (ARPA) - Public Law 117-2, the American Rescue Plan Act of 2021 (ARPA) directed the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide additional funds to support states through Block Grants to address the effects of the COVID -19 pandemic for Americans with mental illness and substance use disorders. The grant includes funding for primary prevention, pregnant women services, substance use treatment services, substance use treatment services and gaps which includes school linked health grants and the Pathfinder Companion finder pilot.	$ 244	$ 10,000	$ 10,551	$ 7,810		-
HHS 93.958	MHBG-ARPA - This funding provides COVID emergency relief funding for the Community Mental Health Services (MHBG) Block Grant Program, in accordance with the Coronavirus Response and Relief Supplement Appropriations Act, 2021 [P.L. 116-260]. The awarded funds must be used for activities consistent with the MHBG program requirements. The grant includes: Enhancing and expanding Mental Health Crisis services; Expanding First Episode Psychosis services and programs; Increasing Mental Health services and programs for the American Indian communities; Expanding Culturally Specific and relevant Mental Health Services; Increasing Mental Health Recovery Supports and Services; Workforce Development and Trainings for Providers of Mental Health Services; Addressing Gaps in Equity.	$ -	$ 10,488	$ 10,488	$ 10,488		
HHS 93.959	Substance Abuse Block Grant-American Rescue Plan - COVID - MITIGATION: This grant is through the American Rescue Plan Act of 2021. Funds can be used to expand dedicated testing and mitigation resources for people with mental health and substance use disorders.	$ -	$ 613	$ 140	$ 37		-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 93.958	Community Mental Health Services Block Grant- American Rescue Plan ACT COVID Mitigation plan: Funds can be used to expand dedicated testing and mitigation resources for people with mental health and substance use disorders. Funds can be expended on: guidance and training curriculum; apply CDC mitigation framework in rural communities; rapid onsite COVID testing; BH services for people in short term housing; testing and PPE for staff and consumers in shelters, group homes, residential treatment facilities; day programs, and room and board programs; expand local or tribal programs workforce to implement COVID-response services for those connected to the behavioral health system; improve access to testing and information for undeserved; install temporary structures, lease of properties, and retrofit facilities as necessary to support COVID testing and COVID mitigation; promote behaviors that prevent the spread of COVID and other infectious diseases; maintain healthy environments; behavioral health services to staff working as contact tracers and other members of the COVID-related workforce; contact tracing.	$ 313	$ 386	$ 145	$ -	No	-
HHS 93.958	Mental Health Block Grant-Coronavirus Response and Relief Supplement Appropriations Act, 2021 [P.L. 116-260] (CAA): The Substance Abuse and Mental Health Services Administration (SAMHSA) released funding to states through the Community Mental Health Services Block Grant (MHBG) program to assist in response to the COVID-19 pandemic. MHBG is designed to provide comprehensive community mental health services to adults with serious mental illness (SMI) or children with serious emotional disturbance (SED).	$ 727	$ 11,765	$ 7,000	$ -		

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 93.747	Coronavirus Response and Relief Supplemental Appropriations Act of 2021: Grants to Enhance Adult Protective Services to Respond to COVID–19. The purpose of this funding is to enhance, improve, and expand the ability of Adult Protection Service (APS) is to investigate allegations of abuse, neglect, and exploitation in the context of COVID–19. Examples of activities consistent with the purposes of the authorizing legislation include: costs associated with establishing new, or improving existing processes for responding to alleged scams and frauds, especially related to COVID–19 vaccine or cure scams; costs associated with community outreach; Costs associated with providing goods and services to APS clients related to COVID–19; acquiring personal protection equipment and supplies.	$ 33	$ 1,154	$ 1,991	$ 1,355	No	-
USDA 10.568	TEFAP BBB (CARES) - These funds will be used to cover costs associated with program management and storage and distribution of USDA foods and create a more resilient food system through educational training.	$ 1,300	$ 198	$ -	$ -		-
HHS 93.234	TBI 2021: This grant project is a partnership between the Department of Human Services, Department of Health, University of Minnesota, Minnesota Brain Injury Alliance, and National Association for State Head Injury Association. Our partnership goals are (1) TBI Advisory Committee (TBI-AC) will develop a multicultural approach to bring new members to the committee (2) Respond to the intersection of COVID-19 and brain injury (3) Direct support towards racial equity and address the impact of systemic racism; (4) Enhance Resource Facilitation (RF) programming and infrastructure for equity and satisfaction (5) Supporting providers who work with individuals experiencing housing instability and their support systems by developing a training and screening model (6) Develop a data driven system accessible by brain injury partners to help in decision making and planning.	$ 73	$ 146	$ 90	$ 81		

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 93.044C	Expanding the Public Health Workforce within the Aging Network for States. The American Rescue Plan Act of 2021 provided funding to recruit, hire, and train public health workers to respond to the COVID-19 pandemic and prepare for future public health challenges. ARPA directed that funds may be used to offset costs of hiring a range of public health professionals, including but not limited to social support professionals, community health workers, communication and policy experts and "other positions as may be required to prevent, prepare for, and respond to COVID-19." ACL's Expanding the Public Health Workforce within the Aging and Disability Networks program provides funding to help cover the costs of staff to conduct these crucial public health activities. Professionals funded through this program provide a wide range of public health services and supports.	$ -	$ 400	$ 400	$ 400		-
HHS 93.324C	SHIP: Expanding the Public Health Workforce within the Aging and Disability Networks: State Health Insurance Assistance Program (SHIP) 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.	$ -	$ 117	$ 117	$ 117		
HHS 93.788	MN SOR 2022- The purpose of this program is to address the opioid overdose crisis by providing resources to states and territories for increasing access to FDA-approved medications for the treatment of opioid use disorder (MOUD), and for supporting the continuum of prevention, harm reduction, treatment, and recovery support services for opioid use disorder (OUD) and other concurrent substance use disorders.	$ -	$ 10,818	$ 12,539	$ 5,000		
HHS 93.558	TANF ARP Pandemic Emerg Assist - to provide non-recurrent short-term cash payments or other benefits to Minnesotan families.	$ -	$ 12,231	$ -	$ -		-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
FEMA 97.036	FEMA Shelter Project: FEMA Funds Provided Emergency Temporary Staffing for protective measures to provide personnel to residential group settings serving vulnerable populations that were experiencing a staff shortage due to a COVID-19 outbreak at jurisdiction wide from 4/1/2021 to 6/30/2021.	$ 125	$ -	$ -	$ -		-
FEMA 97.036	FEMA funds Provided Non-congregate Shelter for COVID -19 positive and/or presumed positive or exposed individuals from 1/1/2021 to 5/31/2021.	$ 63	$ -	$ -	$ -		-
FEMA 97.036	FEMA funds Provided short-term emergency temporary staffing for direct support personnel during the COVID-19 outbreak at Minnesota (Jurisdiction-wide) from 1/1/2021 to 3/31/2021.	$ 386	$ -	$ -	$ -		-
FEMA 97.036	FEMA funds Provided Non congregate sheltering for Beltrami county by utilizing contracts to provide meals, hotels and county staffing for those in isolation or quarantine spaces for the homeless population for people within the community in response to the COVID-19 pandemic from 1/1/2021 to 6/30/2021.	$ 29	$ -	$ -	$ -		-
FEMA 97.036	FEMA Funds Provided non-congregate shelter (NCS) for COVID 19 positive or exposed individuals at hotels within the Duluth area from 8/1/2020 to 2/28/2021.	$ 602	$ -	$ -	$ -		-
HHS 93.498	Provider Relief Fund. The CARES Act provides relief to health care providers for healthcare related expenses or lost revenues attributed to coronavirus. Funding is to be used to offset the expenses or lost revenues resulting from COVID-19 incurred by the hospitals operated by Direct Care and Treatment.	$ 273	$ -	$ -	$ -	No	0.00

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
HHS 93.137	Demonstrating Effective Policies To Promote Black Youth Mental Health: This grant was solicited for projects from eligible public and non-profit entities to demonstrate the effectiveness of general health and wellness policies in improving Black youth mental health, including suicide prevention. This grant was solicited for projects from eligible public and non-profit entities to demonstrate the effectiveness of general health and wellness policies in improving Black youth mental health, including suicide prevention.	$ -	$ 400	$ 400	$ 350	No	0.70
	The Bipartisan Safer Communities Act (BSCA) (P.L. 117-159): provides in supplemental funding for the Community Mental Health Services Block grant (MHBG), to enable States, the District of Columbia, and territories to expand access to mental health care. With the impact of COVID-19 and mass shootings prominent in the national discourse, this grant focuses on mental health treatment and recovery services. The Substance Abuse and Mental Health Services Administration (SAMHSA) is recommending that state behavioral health systems examine what is needed to address the need for mental health services in the aftermath of mass shootings and other traumatic events in communities.	$ -	$ 1,007	$ 1,007	$ -	No	1.00
10.187	Under the statutory authority of the Commodity Credit Corporation (CCC), the U.S. Department of Agriculture (USDA) is providing additional support for emergency food programs to address supply chain challenges and elevated food costs. Funds will be distributed through The Emergency Food Assistance Program (TEFAP) in the form of additional food and administrative resources to Food Banks. Funding will be provided in multiple phases to the state.	$-	$ 1,000	$ 1,000	$ 1,000		1.00
93.564	MN Safe Access for Victims' Economic Security (MN-SAVES) - SAVES will implement comprehensive domestic violence safety policies, procedures, and outreach activities to enhance safety for victims of domestic violence in the child support program.	$ -	$ 386	$ 806	$ 210	No	

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
93.564	Advancing Equity In Child Support - Examine child support services, policies, and procedures to address disproportional access to services.		$ -	$ 1,783	$ 1,783		
	Federal Fund – Agency Total [3000 Fund]	**$ 14,301,610**	**$ 16,672,628**	**$ 15,333,789**	**$ 15,262,406**		**251.24**
HHS CFDA 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 programs that help low-income families with children.	$ 182,224	$ 266,213	$ 275,549	$ 275,941	Yes	14.70
	TANF Fund – Agency Total [3001 Fund]	**$ 182,224**	**$ 266,213**	**$ 275,549**	**$ 275,941**		**14.70**
U.S. Department of the Treasury 21.019	Emergency Shelter Grants	$ 22,040	$ -	$ -	$ -		-
U.S. Department of the Treasury 21.019	Emergency Temporary Staffing Pool for Group Settings	$ 2,310	$ -	$ -	$ -		-
U.S. Department of the Treasury 21.019	Enhanced Homecare Benefit for American Indian Elders	$ 23	$ -	$ -	$ -		-
U.S. Department of the Treasury 21.019	Homeless, Victim Services, and Isolation Space COVID Response	$ (49)	$ -	$ -	$ -		-
	Coronavirus Relief Fund – Agency Total [3010 Fund]	**$ 24,323**	**$ -**	**$ -**	**$ -**		**-**

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
U.S. Department of the Treasury 21.027	School Linked Mental Health Grants: Funding for mental health services for students and educators through School-linked Mental Health Grants.	$ 5,976	$ 35	$ -	$ -		-
U.S. Department of the Treasury 21.027	Shelter Facilities: Funding for programs, settings and services eligible under the Emergency Services Program (ESP) to help them operate safely over the long-term while preventing transmission of COVID-19.	$ 15,000	$ -	$ -	$ -		-
U.S. Department of the Treasury 21.027	Shelter: Creation of a homeless shelter emergency response team and targeted, immediate response activities to mitigate or prevent outbreaks in congregate settings serving people experiencing homelessness, including survivors of domestic violence.	$ 10,000	$ -	$ -	$ -		-
U.S. Department of the Treasury 21.027	Nursing Facilities Grants: Nursing Facility Emergency Grants for Additional Staffing to nursing facilities that agree to use at least 90% of the new funding for hiring and retention bonuses to hire or retain existing employees.	$ 49,900	$ -	$ -	$ -		-
U.S. Department of the Treasury 21.027	Children in Crisis: Transition children with behavioral health crisis from emergency departments across Minnesota.	$ 1,068	$ 1,792	$ -	$ -		-
U.S. Department of the Treasury 21.027	Food Support Grants: Grant funds available to a diverse network of food resources such as food shelves, food banks, and meal programs, representing the efforts of community based organizations, Tribal Nations, and local units of government.	$ 13,000	$ 1,000	$ -	$ -		-
U.S. Department of the Treasury 21.027	Child Care Stabilization: Payments to child care providers to help them remain operating and serving children while facing increased costs and staffing challenges related to the recent surge in COVID-19 cases and to follow public health guidance.	$ 19,969	$ -	$ -	$ -		-
U.S. Department of the Treasury 21.027	Basic Sliding Fee: Temporarily clear the Basic Sliding Fee waiting list and create stability and access to child care for approximately about 340 families and 680 children in Calendar Year 2023.	$ -	$ 7,000	$ -	$ -		-
U.S. Department of the Treasury 21.027	Ramsey County Shelter: Funds support 100-200 shelter beds in St. Paul and Ramsey County through June 2023.	$ -	$ 6,000	$ -	$ -		-

(Dollars in Thousands)

Federal Agency and CFDA #	Federal Award Name and Brief Purpose	FY2022 Actuals	FY 2023 Revised	FY 2024 Revised	FY 2025 Revised	Required State Match or MOE?	FTEs
U.S. Department of the Treasury 21.027	Food Support: Provide grant funds to food shelves, food banks, and meal programs, operated by community based organizations, Tribal Nations, and local units of government.	$ -	$ 5,100	$ -	$ -		-
U.S. Department of the Treasury 21.027	School Mental Health: Grants to fund innovative projects to improve mental health outcomes for youth attending an Intermediate School District organized under Minnesota Statutes 136D.01 that provides instruction to students in a setting of federal instructional level 4 or higher.	$ -	$ 4,400	$ -	$ -		-
U.S. Department of the Treasury 21.027	Hennepin County Shelter: Grant to support Avivo Village in Hennepin County, which is a program built to support individuals experiencing unsheltered homelessness along a pathway to securing permanent housing, through June 2023.	$ -	$ 1,800	$ -	$ -		-
U.S. Department of the Treasury 21.027	Mental Health Support: One-time grant funding for Children Residential Facility (CRF) Providers to provide care to children with complex needs.	$ -	$ 2,500	$ -	$ -		-
U.S. Department of the Treasury 21.027	Navigator Grants: Support navigator organizations that will play an essential role in helping Minnesota Health Care Programs' enrollees with the renewal process, particularly enrollees with limited English proficiency and in BIPOC communities.	$ -	$ 370	$ -	$ -		-
	American Rescue Plan State Fiscal Recover – Agency Total [3015 Fund]	**$ 114,913**	**$ 29,997**	**$ -**	**$ -**		**-**
	Total Agency Federal Funds	**$ 14,623,069**	**$ 16,968,838**	**$ 15,609,338**	**$ 15,538,347**		**265.94**

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
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.	$ 622	$ 622	$ 622	$ 622
ADAP Drug Rebates-Title II Grants M.S. 256.01, subd 20	Dedicated funding resulting from ADAP drug rebates that supplements state and federal allocations to maintain private insurance coverage and/or purchase HIV related drugs. In addition, the funds can be spent on allowed core and support services per the federal Ryan White regulations .	$ 12,763	$ 6,440	$ 6,440	$ 6,440
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.	$ 46	$ 68	$ 20	$ 20
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.	$ 5,365	$ 5,512	$ 5,512	$ 5,512
Senior Nutrition Program Grants M.S. 256.9752	Grants to Area Agencies on Aging to provide nutrition services including congregate meals to 35,284 people and home-delivered meals to 12,112 people in FY 2019. This count includes all funding sources including federal funding (Title III) under the Older Americans Act.	$ 2,658	$ 2,695	$ 2,695	$ 2,695
Housing Support Program M.S. 256I	Housing Support 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.	$ 179,487	$ 208,230	$ 203,973	$ 211,400
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.	$ 1,234	$ 1,524	$ 1,524	$ 1,524
Navigator MA Enrollment Grants-HCAF (M.S. 256.962)	These funds provide incentive payments for more than 725 individuals and entities across the state providing application assistance for enrollees in the Medical Assistance program.	$ 310	$ 316	$ 310	$ 310
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.	$ 131	$ 479	$ 479	$ 479
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.	$ 1,569	$ 1,429	$ 1,509	$ 1,509

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
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, non-residential 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. About 700 to 800 individuals receive non-residential or residential treatment per year. The total served represents a combined number of individuals that received treatment.	$ 986	$ 751	$ 1,508	$ 1,508
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 2,580 older Minnesotans in FY2019, at an average monthly cost of $1,072.	$ 13,283	$ 48,133	$ 48,156	$ 48,192
South Central Crisis Program Laws of 2010, 1st SS, Ch.1 Art. 25, subd. 10(a)	This grant funds Psychiatric Urgent Care for people in crisis. It also funds Residential Crisis Stabilization services for those people who are uninsured or underinsured.	$ 565	$ 575	$ 600	$ 600
Children's Trust 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.	$ 1,255	$ 179	$ 75	$ 75
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.	$ (14)	$ 72	$ 50	$ 50
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 hearing loss, to remain independent and part of their communities.	$ 2,822	$ 2,846	$ 2,846	$ 2,846
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 2019, MFIP Child Care Assistance paid for child care for an average of 16,689 children in 8,065 families per month.	$ -	-	$ 25,442	$ 90,655

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
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 an average month, the programs serve about 80,000 children and their parents or caretakers in almost 29,000 households. See also federal funds.	$ 88,957	$ 90,364	$ 90,926	$ 91,818
Rural Real Time - Grant M. S. 237.32, 256C.30	Grants to television stations in Minnesota to provide real-time captioning of live TV news programming where real-time captioning does not exist.	$ 273	$ 149	$ 149	$ 149
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.	$ 117	$ 610	$ 610	$ 610
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. 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.	$ 8,536	$ 8,679	$ 8,679	$ 8,679
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. Over 11,000 staff in 2,756 family child care providers are active users on Develop, Minnesota's Quality Improvement Registry Tool. More than 3,000 individuals received coaching and support services to increase quality of child care in 2019.	$ 516	$ 1,007	$ 1,007	$ 1,007
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.	$ 13,676	$ 15,920	$ 16,384	$ 16,384
Food Shelf Grants M. S. 256E.34	Additional grants for purchase and distribution of food to food shelves throughout the state.	$ 1,318	$ 1,318	$ 1,318	$ 1,318
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	$ 55,814	$ 55,814
Child Care Integrity Grants M.S. 119B	Grants to counties to support fraud prevention activities.	$ 106	$ 122	$ 147	$ 147
Foster Care Recruitment M.S. 256.01, subd. 36	Federal financial participation for foster care recruitment.	-	-	$ 76	$ 76
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.	$ 3,356	$ 3,330	$ 3,449	$ 3,449

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
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.	$ 292	$ 300	$ 300	$ 300
Aid to Counties- Fraud Prevention Grants (FPG) M.S. 256.983	Grants to counties for the Fraud Prevention Investigation Program, enabling early fraud detection and collection efforts.	$ 1,432	$ 1,620	$ 1,768	$ 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.	$ 3,148	$ 3,184	$ 3,221	$ 3,221
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.	$ 1,442	$ 1,377	$ 1,482	$ 1,482
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.	$ 19,540	$ 21,000	$ 21,000	$ 21,000
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	$ 170	$ 170
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.	$ 977	$ 590	$ 1,065	$ 1,065
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 1.1 million uninsured or underinsured Minnesotans who meet income eligibility requirements. This program is managed by the state under guidance from the federal government.	$ 5,032,393	$ 7,255,479	$ 7,806,855	$ 8,096,950
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.	$ 1,464	$ 1,619	$ 1,758	$ 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.	$ 1,182	$ 1,191	$ 1,191	$ 1,191
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.	$ 3,035	$ 4,277	$ 4,277	$ 4,277

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
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 7,284 families in FY 2019.	$ 53,616	$ 53,350	$ 53,362	$ 53,366
Disability Linkage Line M.S. 256.01, subd. 24	Disability Linkage Line (DLL) now known as the Disability Hub MN 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.	$ 605	$ 605	$ 605	$ 605
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.	$ 245	$ 250	$ 250	$ 250
Minnesota Care Grants M.S. 256L and 256B	Minnesota Care Grants pay for health care services for about 81,000 Minnesotans who lack access to affordable health insurance.	$ 61,225	$ 286,320	$ 305,333	$ 290,490
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.	$ 50,060	$ 55,849	$ 55,668	$ 57,265
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, non-residential 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 to 800 individuals receive non-residential or residential treatment per year. The total served represents a combined number of individuals that received treatment.	$ 380	$ 210	$ 208	$ 208
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.	$ 49,691	$ 51,447	$ 51,788	$ 52,114
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 nearly 1,500 people each year.	$ 6,676	$ 8,390	$ 8,390	$ 8,390
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.	$ 163	$ 163	$ 163	$ 163

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
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.	$ 40,305	$ 31,595	$ 3,973	$ 3,973
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.	$ 32	$ 22	$ 7,388	$ 7,806
Red Lake Band Child Welfare Costs M.S. 245.765 Sub 1	Grants to counties for child welfare costs associated with children who are enrolled members of Red Lake Nation.	$ 487	$ 361	$ 487	$ 487
Hearing Loss Mentors M.S. 256.01, subd. 2	Grant funding pays for deaf and hard of hearing mentors to work with families who need to learn American Sign Language (ASL) and other communication and life skill strategies to communicate with and support their children who are deaf and hard of hearing.	$ 9	$ 40	$ 40	$ 40
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.	$ 2,674	$ 3,128	$ 3,128	$ 3,128
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.	$ 833	$ 6,216	$ 6,844	$ 6,844
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. See also Insurance grants.	$ 1,156	$ 1,156	$ 1,156	$ 1,156
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.	$ 2,185	$ 2,980	$ 2,980	$ 2,980
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.	$ 300	$ 300	$ 300	$ 300
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. Return to Community is an intensive options counseling service provided by the Senior Linkage Line®, that helps people successfully return to and remain in their homes. From 2013 through 2019, 23,000 people have been contacted for support. Of those, the Senior LinkAge Line helped over 6,000 older adults return home from a nursing facility and supported over 8,000 people remain in their community.	$ 5,816	$ 6,685	$ 6,686	$ 6,686

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
Adoption IV-B Grants	Federal reimbursement of Title IV-B activities eligible for Title IV-E reimbursement of adoption services to adoptive families.	$ 634	$ 313	$ 313	$ 313
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	$ 793	$ 786	$ 786
Navigator RFP Outreach Grants – HCAF (M.S. 256.962)	These funds provide incentive payments for more than 725 entities and individuals across the state providing application assistance for MinnesotaCare enrollees.	$ 36	$ 40	$ 40	$ 40
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%).	$ 978	$ 1,036	$ 1,036	$ 1,036
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.	$ 4,407	$ 4,412	$ 4,412	$ 4,412
Adult Mental Health Integrated Fund M.S. 245.4661, subd. 6 and 256E.12	including crisis response and case management services. For most counties, this includes integrated administration of Adult MH Community Support Grants and Residential Treatment Grants.	$ 31,845	$ 34,598	$ 34,695	$ 34,695
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.	$ 125	$ 125	$ 125	$ 125
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.	$ 80	$ 750	$ 750	$ 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.	$ 15,286	$ 15,504	$ 15,504	$ 15,504
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.	$ 105	-	$ 542	$ 542
Navigator Outreach Grants - General Fund (M.S. 256.962)	These funds provide incentive payments for more than 600 entities and individuals across the state providing application assistance for Medical Assistance enrollees.	$ 90	$ 90	$ 90	$ 90
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. Funds used at local level for match.	$ 3,923	$ 4,903	$ 4,928	$ 4,928

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
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.	$ 1,019	$ 1,024	$ 1,024	$ 1,024
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.	$ 161	$ 67	$ 67	$ 67
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	$ 10
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.	$ 1,520	$ 1,951	$ 1,988	$ 1,988
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.	$ 1,052	$ 1,064	$ 1,064	$ 1,064
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).	$ 12	$ 13	$ 26	$ 26
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.	$ 49	$ 49	$ 49	$ 49
Advocating Change Together –ACT M.S. 256.477	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.	$ 133	$ 133	$ 133	$ 133
Gambling Receipts Grants M.S. 297E.02, subd. 3	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.	$ 1,052	$ 4,273	$ 1,758	$ 1,849
Minnesota Food Assistance Program M.S. 259D.053	State funded food benefits for legal non-citizens who do not qualify for federal food stamps.	$ 927	$ 1,081	$ 2,269	$ 1,675
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.	$ 530	$ 121	$ 121	$ 121

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
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 1.1 million uninsured or underinsured Minnesotans who meet income eligibility requirements. This program is managed by the state under guidance from the federal government.	$ 602,596	$ 353,265	$ 869,524	$ 612,099
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.	$ 192	$ 192	$ 192	$ 192
Problem Gambling Rider M.S. 297E.02, subd. 3	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	-	-
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. This grant is both treatment and prevention focused. This grant will be appropriated to the Department of Health starting in FY 2024.	$ 740	$ 750	-	-
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.	$ 51	$ 100	$ 100	$ 100
Local 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 and 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).	$ 6	$ 254	$ 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.	$ 225	$ 344	$ 344	$ 344
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	$ 1,986	$ 2,250	$ 2,250

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
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	$ 811	$ 811
SSI-IAR Disability Hub 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.	$ 138	$ 140	$ 140	$ 140
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%.	$ 800	$ 817	$ 817	$ 817
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.	$ 1,650	$ 1,739	$ 1,739	$ 1,739
Gaps Analysis Laws of 2013, Chap. 108, Article 15, subd 2(h)	Provides ongoing support to counties to participate in the gaps analysis survey of the HCBS system.	$ 145	$ 69	$ 218	$ 218
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.	$ 1,018	$ 1,585	$ 1,585	$ 1,585
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.	$ 502	$ 502	$ 502	$ 502
Disability Linkage Line MA Eligible 50% M.S. 256.01, subd. 2, (aa)	State share of funding for work completed by the Disability Linkage Line (now known as the Disability Hub MN) that is related to Medical Assistance and therefore eligible for 50% FFP based on activities reporting.	$ 700	$ 900	$ 900	$ 700
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.	$ 18,014	$ 18,065	$ 18,065	$ 18,065
Navigator BHP – HCAF (M.S. 62V.05, Subd. 4)	These funds provide incentive payments for more than 725 entities and individuals across the state providing application assistance for MinnesotaCare enrollees.	$ 317	$ 252	$ 3,115	$ 3,115
340B Drug Rebates-Title II Grants M.S. 256.01, subd 20	Dedicated funding resulting from ADAP drug rebates that supplements state and federal allocations to maintain private insurance coverage and/or purchase HIV related drugs. In addition, the funds can be spent on allowed core and support services per the federal Ryan White regulations. This portion of the funding is the state share of the rebate funding.	$ 3,821	$ 3,973	$ 2,392	$ 2,392

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
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).	$ 978	$ 1,000	$ 1,000	$ 1,000
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.	$ 258	$ 7	-	-
Northstar Care for Children (M.S. 256N)	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. Northstar Care for Children consolidates and simplifies administration of three programs: Family Foster Care, Kinship Assistance (which replaces Relative Custody Assistance) and Adoption Assistance. Northstar served an average of 15,297 children per month in FY 2019.	$ 93,655	$ 123,679	$ 123,647	$ 131,697
Other Long Term Care Grants M.S. 256.0921	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 and community integration and inclusion.	$ 883	$ 1,925	$ 1,925	$ 1,925
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 1998, 3,190 FAIM accountholders have completed the program and deposited nearly $4.65 million into savings accounts acquiring over 2,500 long-term financial assets including, purchased homes, post-secondary education and capitalized businesses.	$ 325	$ 325	$ 325	$ 325
Food Shelf Grants M. S. 256E.34	Grants for purchase and distribution of food to food shelves throughout the state, including some administrative costs.	$ 375	$ 375	$ 375	$ 375
Text Message M.S. 245.4889	Grant to a nonprofit organization to establish and implement a statewide text message suicide prevention program. In 2016-2017, Text-4-Life responded to a total of 22,162 text message conversations in 54 counties throughout Minnesota. In 2018-2019, Crisis Text Line (which replaced TXT4Life) had 6,208 text message conversations in 68 counties through MN. This service started in April 2018.	$ 979	$ 1,125	$ 1,125	$ 1,125
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. During the 2021 legislative session, this funding was eliminated for FY 2022 and FY 2023 with the funding returning starting in FY 2024. Federal funding is to be used instead of state funds during FY 2022 and FY 2023.	-	-	$ 23	$ 23

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
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.	$ 236	$ 236	$ 236	$ 236
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.	$ 62	$ 100	$ 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.	$ 547	$ 1,532	$ 2,089	$ 2,089
Child welfare work M.S. 259A	Grants to tribal nations for child welfare work.	$ 475	$ 475	$ 475	$ 475
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.	$ 1,183	$ 1,225	$ 1,225	$ 1,225
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.	$ 4,270	$ 4,550	$ 4,550	$ 4,550
ACT Quality Improvement & Expansion Grants Laws of 2017, 1st SS, Ch.6 Art. 18, Sec. 2, subd. 30	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.	$ 381	$ 500	$ 500	$ 500
Navigator MA Enrollment Grants (M.S. 256.962)	These funds provide incentive payments for more than 725 individuals and entities across the state providing application assistance for enrollees in the Medical Assistance program.	$ 320	$ 320	$ 320	$ 320
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	$ 23,350	$ 23,870

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
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; and Supporting families in the context of their communities and tribes to safely divert them from the child welfare system, whenever possible. Grants were awarded to tribes, counties and community agencies.	$ 1,603	$ 1,419	$ 1,650	$ 1,650
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	$ 1,400	$ 1,400	$ 1,400
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	$ 500	$ 500	$ 500
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.	$ 2,212	$ 2,212	$ 2,212	$ 2,212
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.	$ 610	$ 734	$ 750	$ 750
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.	$ 600	$ 600	$ 600	$ 600
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.	$ 1,750	$ 1,811	$ 1,811	$ 1,811
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.	$ 320	$ 363	$ 363	$ 363

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
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.	$ 319	$ 363	$ 725	$ 725
Minnesota Adult Abuse Reporting 2021 First Special Session Law, Ch. 7, Art. 16, Sec. 2, Subdiv. 27	Grants provide funding to assist the Minnesota Board on Aging in handling all reports of adult abuse for older adults and people with disabilities in various care settings.	$ 1,653	$ 1,764	$ 1,819	$ 1,819
Mental Health Innovations Grants M.S. 246.18, Subd 4A	These grant funds are dedicated to finding innovative approaches for improving access to and the quality of community-based, outpatient mental health services. Programs are focused on helping people with mental illness receive effective and culturally specific services in their community. These were new funds in 2018.	$ 1,143	$ 1,500	$ 1,500	$ 1,500
MDH Help Me Grow M.S. 256.01 Subd. 2	This is an interagency grant contract with the Minnesota Department of Health to provide resources for referral information to families and providers through the Board on Aging MNHELP.info.	$ 26	-	-	-
Self Directed Caregiver Grants. Laws of Minnesota, 2017 1st Special Session, Chapter 6 Article 3, Sections 6-7. Codified- M.S. 256.975 subd. 12.	Grant to provide assistance to family caregivers who help older adults age in place.	-	-	$ 477	$ 477
Arnold Lifeskills Substance Use Prevention Grant MS 256 01 25	These grant funds support middle school substance use prevention programming. Programs are designed to reduce the likelihood of youth smoking and drinking	$ 131	$ 315	$ 315	$ 315
Host Home Program, M.S. 471.59	Funds to establish the host home program, interagency agreement with Minnesota Housing Finance Agency.	$ 175	$ 7	-	-
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. Several projects have been approved by CMS in and will be expended over the course of the next three years.	$ 596	$ 1,654	$ 2,753	$ 2,753
Parent Support for Better Outcomes Grants Laws 2019, Special Session 1, Chapter 9, Art. 14, Sec 2	One-time appropriation to provide grants to Minnesota One-Stop for Communities to provide mentoring, guidance, and support services to parents navigating the child welfare system.	$ 150	$ 150	$ 150	$ 150
Safe Harbor Exploited Youth Laws 2019, chapter 9, article 14, sec 22	Grants for safe harbor for exploited youth providers trauma-informed support to young people who are sexually exploited.	$ 369	$ 500	$ 500	$ 500

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
Shelter Linked Youth Mental Health Grants 256K.46	Grants to provide mental health services to homeless or sexually exploited youth.	$ 215	$ 2,500	$ 2,500	$ 4,500
Incentive-Based Grants for Customized Living Service Providers 2019 First Special Session Law, Ch. 9, Art. 14, Sec. 2, Subdiv. 27	Incentive-based grants to elderly waiver customized living service providers under 2019 First Special Session Law, Ch. 9, Art. 4, Sec. 28.	$ 314	-	-	-
Community Living Infrastructure Grants Laws of 2017, 1st SS, Ch.6 Art. 18, Sec. 2, subd. 24J	The Community Living Infrastructure grant program supports the needs of people with disabilities and housing instability who want to live in the community but are faced with significant barriers in transitioning into community living from institutions, licensed facilities or homelessness. The Community Living Infrastructure funding is currently awarded to 18 grantees beginning in FY2020	$ 2,685	$ 2,685	$ 2,685	$ 2,685
Real-Time Housing Website Laws of 2017, 1st SS, Ch.6 Art. 18, Sec. 2, subd. 24K	The Real Time Housing Website grant is for the design, development and maintenance of a fully accessible and usable website, including an application, to track real-time-housing openings for people with disabilities across the state of Minnesota. The Real Time Housing funding is currently awarded to one grantee to develop the website.	-	$ 150	$ 150	$ 150
Housing Benefit Website (HB101) Laws of 2017, 1st SS, Ch.6 Art. 18, Sec. 2, subd. 24L	Housing Benefit grant money pays for the development and maintenance of the Housing Benefits 101 website which helps persons with disabilities understand types of housing available to them depending the person's situation, needs and desires.	$ 130	$ 130	$ 130	$ 130
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. Funds may also be used at the local level for federal Housing and Urban Development housing match.	$ 6,910	$ 6,910	$ 6,910	$ 6,910
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.	$ 457	$ 489	$ 489	$ 489
Safe Harbor Laws 2013, Chapt 108, Art 14, Sec2, subd 6(g) and Laws 2014, Chapt 312, Art 30, sec 2, subd 4(b)	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.	$ 2,640	$ 2,827	$ 2,800	$ 2,800
Safe Harbor Program Outreach M.S. 256K.45	Grants to organizations to increase awareness of the safe harbor program.	$ 250	$ 250	$ 250	$ 250

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
Service Employees International Union (SEIU).	Grants for training for providers. This change corrects funding allocations as originally established in Article 1, Section 53. Article 18, Section 2, subd 7(f). Article 18 section 2, subd 15(b). Effective July 1, 2017.	$ 71	$ 87	$ 87	$ 87
First Episode Psychosis Grants M.S. 245.4889	Grants to provide evidence-based practice interventions for youth and adults ages 15-40 who are experiencing a first episode of psychosis.	$ 301	$ 301	$ 301	$ 301
American Indian Early Intervention Grants	Grants to organizations serving American Indian families to provide stability and address issues.	$ 354	$ 859	$ 900	$ 900
Preschool Development Grant, Community Resource Hubs M.S. 471.59	Community resource hubs that offer direct services and help families navigate existing resources, including economic assistance, disability services, healthy development and screening, family well-being and mental health, early learning and child care, dental care, legal services, and culturally specific services.	$ 626	$ 2,518	$ 3,237	-
Behavioral Health Fund Grants M.S. 254B.02, Sund.1	The Behavioral Health Fund 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. Almost all treatment providers in the state are enrolled as BHF providers.	$ 168,314	$ 201,369	$ 211,086	$ 216,156
Behavioral Health Support Grant MS 254B.02 1	The Behavioral Health Fund 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. Almost all treatment providers in the state are enrolled as BHF providers. This grant funding provides other services.	$ 234	-	$ 500	$ 500
Preschool Development Grant MS 471.59	Interagency agreement between the Department of Human Services and Department of Education for preschool development funding including family well being and mental health.	$ 535	$ 420	-	-
OER - Advisory Council Grants	Grants appropriated in the Opioid Epidemic response funding that are awarded through the Opiate Epidemic Advisory Council. The appropriations vary per year depending on revenue generated in the fund. Grants are awarded based on the outcomes noted under M.S. 256.042 subd. 3.	$ 1,217	$ 6,169	$ 4,884	$ 6,314
Opioid Epidemic Response Fund Child Protection Grants. M.S. 256.043	Grants to county and tribal social service agencies to provide child protection services to children and families who are affected by addiction.	$ 2,511	$ 4,003	$ 6,170	$ 4,884
Opiate Epidemic Response - Adult Mental Health MS 211 007 16 002 031	This funding s appropriated from the opiate epidemic response fund to the commissioner of human services to award grants to Tribal nations and five urban Indian communities for traditional healing practices to American Indians and to increase the capacity of culturally specific providers in the behavioral health workforce. The grant expires after FY 2024.	$ 1,862	$ 2,000	$ 2,000	-

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
Opiate Epidemic Response - ECHO Grant MS 211 007 16 002 033, MS 19 63 3 1, para 1, MS 211 007 16 14	This funding is appropriated from the opiate epidemic response fund to the commissioner of human services to Hennepin Health for the opioid-focused Project ECHO program ($200,000 per year) and another $200,000 per year for a competitive ECHO project. The funding is available from FY 2022 through FY 2024.	$ 200	$ 400	$ 400	-
Opiate Epidemic Response - Chemical Dependency Treatment Support Grants MS 211 007 16 002 033	This grant funding is to a nonprofit organization that has provided overdose prevention programs to the public in at least 60 counties within the state, for at least three years, has received federal funding before January 1, 2019, and is dedicated to addressing the opioid epidemic. The grant must be used for opioid overdose prevention, community asset mapping, education, and overdose antagonist distribution. The annual appropriation amount is $100,000 and expires after FY 2024.	$ 100	$ 100	$ 100	-
DEED Life Course Grant MS 471.59	An interagency agreement between DHS and DEED for developing a youth in transition communication system.	$ 285	$ 55	-	-
Adult Protective Services to Counties Laws 2021, Ch. 7, Article 16, Sec. 2 , Subdiv. 23	The Adult Protective Services grant provides funding to be used for staffing for protection of vulnerable adults or to expand protective services. Grants are distributed to counties and tribes on a calendar year basis.	-	$ 2,050	$ 2,655	$ 2,655
ARPA Fiscal Recovery Fund (FRF)-American Rescue Plan (ARP) State Fiscal Recovery Funds (SFRF)	Navigators will be critical partners in helping keep eligible Minnesotan's covered during the post COVID emergency unwinding, Navigators assist with annual renewals, changes and post enrollment questions. These funds will support navigators to increase funding for application and renewal assistance through this grant.	-	$ 2,065	-	-
Emergency Services Grants Facility Bonding Fund Laws 2021, Ch. 7,	Funds to build emergency shelter facilities.	-	$ 1,000	$ 1,000	$ 1,000
Court-Appointed Counsel in Child Protection Proceedings. Laws 2021, Ch 7, Article 16	Funds for county costs to provide court-appointed counsel in child protection proceedings. Beginning in FY2024, funds will be distributed based upon a formula recommended by DHS.	-	$ 520	$ 520	-
Grants for Technology for HCBS Recipients 2021 First Special Session Law, Ch.7, Art. 17, Sec. 3	Grants are intended to provide technology assistance, including but not limited to Internet services, to older adults and people with disabilities who do not have access to technology resources necessary to use remote service delivery and telehealth.	-	-	$ 2,500	$ 1,500
Provider Capacity Grants for Rural and Underserved Communities 2021 First Special Session Law, Ch. 7, Art. 17, Sec. 10	Grants provide funding to smaller organizations that offer services to rural or underserved communities with limited home and community-based services provider capacity. The grants are available to build organizational capacity or to build new/expanded infrastructure to access medical assistance reimbursement.	-	-	$ 14,000	$ 8,000

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
Respite Services for Older Adults Grants 2021 First Special Session Law, Ch. 7, Art. 17, Sec. 17, Subdiv. 3	Grants provided to establish a grant program for respite services for older adults.	-	-	$ 4,000	$ 2,000
HCBS Workforce Development Grants 2021 First Special Session Law, Ch. 7, Art. 17, Sec. 20	Grants are intended to address challenges related to attracting and maintaining direct care workers who provide home and community-based services for people with disabilities and older adults.	-	-	$ 5,588	$ 5,588
Age-Friendly Community Grants 2021 First Special Session Law, Ch. 7, Art. 17, Sec. 8, Subdiv. 1	Grants are for intended collaboration with the Department of Human Services, the Minnesota Board on Aging, and the Governor's Council on an Age-Friendly Minnesota. The grants offer communities - including cities, counties, other municipalities, tribes, and collaborative efforts - to become age-friendly communities with an emphasis on structures, services, and community features necessary to support older adult residents over the next decade.	-	-	$ 875	$ 875
Age-Friendly Technical Assistance Grants 2021 First Special Session Law, Ch. 7, Art. 17, Sec. 8, Subdiv. 2	Department of Human Services, the Minnesota Board on Aging, and the Governor's Council on an Age-Friendly Minnesota. This grant program is meant to supplement the Age-Friendly Community Grants program and offer technical assistance to recipients of the Age-Friendly Community Grants to ensure proper implementation and	-	-	$ 575	$ 575
Training Stipend Direct Service Provision MS 211 007 16 002 29A	$1,000,000 in fiscal year 2022 is from the general fund for stipends for individual providers of direct support services as defined in Minnesota Statutes, section 256B.0711, subdivision 1. These stipends are available to individual providers who have completed designated voluntary trainings made available through the State-Provider Cooperation Committee formed by the State of Minnesota and the Service Employees International Union Healthcare Minnesota. Any unspent appropriation in fiscal year 2022 is available in fiscal year 2023. This funding is only available if the labor agreement with SEIU and the State of Minnesota is approved.	$ 1,000	-	-	-
Continuing Care - Parent to Parent Peer Support MS 211 007 16 002 29B	Provides grants for parent-to-parent peer support for families of children with disabilities or special health care needs. The funding is only available in FY 22 and FY 23.	$ 125	$ 125	-	-
Continuing Care - Self Advocacy Grants MS 211 007 16 002 29C	Provides funding for a statewide advocacy network for people with intellectual and developmental disabilities. In the 2021 legislature, the funding was renamed under section 256.477 to “Rick Cardenas Statewide Self-advocacy Network." In 2021, the scope of the grants was increased.	$ 143	$ 143	$ 143	$ 143
Self Advocacy Subgrants MS 211 007 16 002 29C	This funding is a subgrant of the self advocacy grant noted above. This funding is for organizations in Minnesota to conduct outreach to persons working and living in institutional settings to provide education and information about community options	$ 105	$ 105	$ 105	$ 105

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
MN Inclusion Initiative Grant MS 211 007 16 002 29D	Establishes a grant program for self-advocacy groups of people with intellectual and developmental disabilities to develop and organize projects to increase inclusion, improve community integration outcomes, educate decision makers and the public, and advocate for changes that increase access to formal and informal supports and services necessary for greater inclusion.	$ 150	$ 150	$ 150	$ 150
Access to Child Care Grant MS 211 007 16 002 29E	Establishes a grant program for child care providers to expand capacity to serve children with disabilities, including medical complexities, in an inclusive child care setting that serves children with disabilities and children without disabilities in the same setting. A two year competitive grant programs for counties or tribes to expand access to licensed family child care providers or licensed child care centers for children with disabilities. This funding is HCBS FMAP funding and was originally for FY 22 and FY 23. In the 2022 legislative session, the unspent FY 22 funding was carried over to FY 23.	-	$ 500	-	-
Subminimum Wage Phaseout MS 211 007 17 015	Establishes a task force to make recommendations for a plan to phase-out the use of subminimum wage for people with disabilities. This funding is HCBS FMAP funding that is effective through FY 2024.	$ 2,400	$ 5,300	$ 4,500	-
MCIL Access Grant MS 211 007 17 019	Independent Community Living grants- support people with disabilities to live in their own homes and communities by providing accessibility modifications that are unable to be purchased through Medicaid	$ 908	$ 1,290	-	-
Transition to Community - HCBS Article 17 MS 211 007 17 006	Provides administrative funding to assist people to move from facilities or provider-controlled settings to a home of their own. This proposal will help people to exit Anoka-Metro Regional Treatment Center (AMRTC), community mental health psychiatric units, and Community Behavioral Health Hospitals for people who are on the Forensic Mental Health Program (FMHP) or AMRTC waiting lists. It will also assist people receiving disability waiver services living in provider-controlled settings (for example corporate foster care and customized living) to move to a home of their own. This funding is HCBS FMAP funding and it ends after FY 2024.	-	$ 4,000	$ 1,500	-
Housing Transition - HCBS Article 17 MS 211 007 17 005 002	Additional CLI funding to provide expungement assistance to help people overcome barriers to attain their own housing.	$ 504	$ 4,000	$ 3,000	-
Culturally and Linguistically Appropriate Services Grants MS 211 007 16 002 31A	Grants to disability services, mental health, and substance use disorder treatment providers to implement culturally and linguistically appropriate services standards, according to the implementation and transition plan developed by the commissioner.	-	$ 4,481	$ 1,655	-
Whatever It Takes Services Grants MS 211 007 17 006	Expands the Whatever It Takes (WIT) services to include the Community Mental Health Psychiatric Units around the State and the Community Behavioral Health Hospitals (CBHH's) for patients who are on the FMHP or AMRTC waiting lists to divert them from having to be admitted to our State hospital systems.	-	$ 7,000	$ 2,625	-

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
Child Residential Facilities Grants MS 211 007 16 002 32A	Grants to reimburse counties and Tribal governments for a portion of the costs of treatment in children's residential facilities. The commissioner shall distribute the appropriation on an annual basis to counties and Tribal governments proportionally based on a methodology developed by the commissioner.	-	$ 3,943	$ 1,979	$ 1,979
Psychiatric Residential Treatment Families Grants MS 211 007 17 012	Creates a Mobile Person-Centered Unit to facilitate effective transition of children from Psychiatric Residential Treatment Families (PRTFs) and Child & Adolescent Behavioral Health Services (CABHS).	-	$ 5,000	$ 1,875	-
Recovery Community Organization Grants MS 211 007 16 002 33B	Provides grants to RCOs, independent organizations led and governed by representatives of local communities of recovery, to coordinate resources within and outside of the recovery community to increase the frequency and quality of long-term recovery from alcohol and drug addiction.	-	$ 4,000	$ 2,000	-
Customized Living Services Grant 2021 First Special Session Law, Ch. 7, Art. 16, Sec. 2, Subdiv. 27	Grants provide customized living providers serving people on the elderly waiver or disability waivers funding for projects that increase the quality of services.	-	$ 407	$ 1,000	$ 1,000
ALS Caregiver Support Programs 2022 Session Law, Ch. 42, Sec. 3	Grants to the Minnesota Board on Aging for the purposes of caregiver support programs under M.S. 256.9755. Programs receiving funding under this section must include an ALS-specific respite service in their caregiver support program. This appropriation is available until June 30, 2026.	-	$ 628	-	-
Benefit Planning Grants MS 211 007 16 002 029	$600,000 each year for the Disability Hub to support benefits planning. These grants are eligible for 50% FFP due to the work related to eligibility.	$ 600	$ 600	$ 600	$ 600
Person Centered Practices Grants MS 211 007 16 002 029	Regional cohorts will receive multi-year training, coaching and mentoring to use person-centered and collaborative safety practices in ways that benefit people served, employees, organizations, and communities to achieve systems change with measurable positive outcomes.	$ 586	$ 710	$ 710	$ 170
Disability Hub for Families Grants MS 211 007 16 002 029	Starting in FY 2020, appropriates $100,000 and then ongoing $200,000 in FY 2021 for grants to connect families through innovation grants, life planning tools (Life Course), and website information as they support a child or family member with a disability.	$ 195	$ 200	$ 200	$ 200
Electronic Visit Verification Grant MS 211 007 16 002 029	Grant funding for one time cost to help offset the electronic visit verification costs for those providers who use a different vendor than the state contract.	$ 500	-	-	-
Housing Support Grants MS 211 007 16 002 030	State grant funding through the Community Living Infrastructure (CLI) grant program to counties and tribes to integrate housing into their human services work. Funds will be utilized by local entities to assist people with disabilities who are homeless or have housing instability to obtain and maintain housing	-	$ 5,000	$ 5,000	-

(Dollars in Thousands)

Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
Childrens Intensive Service Reform MS 211 007 16 002 032, MS 19 009 14 002 32	Grant funding for start-up grants to prospective psychiatric residential treatment facility sites for administrative expenses, consulting services, Health Insurance Portability and Accountability Act of 1996 compliance, therapeutic resources including evidence-based, culturally appropriate curriculums, and training programs for staff and clients as well as allowable physical renovations to the property.	$ 125	$ 400	$ 400	$ 400
Adult Mental Health Initiative grant MS 211 007 16 002 031	Provides funding to groups of counties and tribes for regional collaboration to build community-based mental health service infrastructure that responds to the unique needs and circumstances of their community.	-	$ 1,674	$ 1,674	$ 1,674
MDE - CoP Group State Reimbursement Grant MS 471.59	An interagency agreement between DHS and the Department of Education (MDE). DHS will support the recruitment, planning, facilitation and evaluation of up to twelve (12) regionally located Stress, Trauma, and Healing Community of Practice ("CoP") groups comprised of up to 10 early childhood professionals from enrolled school districts and community partners. The intent of the CoP groups is to ensure early childhood providers know how to support socio-emotional well-being in young children, their families and themselves. The facilitated CoP will provide opportunities for skill development, application, and reflection. This is the state share of the reimbursement.	-	$ 31	-	-
MDE IAA - CoP Group Grants MS 471.59	Above description is the same- this is for the federal portion of the reimbursement from MDE.	-	$ 32		
ALS Caregiver Support Programs 2022 Session Law, Ch. 42, Sec. 3	Grants to the Minnesota Board on Aging for the purposes of caregiver support programs under M.S. 256.9755. Programs receiving funding under this section must include an ALS-specific respite service in their caregiver support program. This appropriation is available until June 30, 2026.	-	-	$ 5,000	-
IRTS Modification - Adult Mental Health MS 22 099 03 007	Expands eligibility for intensive nonresidential rehabilitative mental health services (IRMHS), also known as YouthACT, to 8-25 year old's (from 16-20)	-	$ 2,796		-
Mental Health Loan Forgiveness MS 22 099 03 011	Grants for individuals who are eligible mental health professionals under Minnesota Statutes section 1144.1501 subdivision 2.	-	$ 2,500	$ 2,500	$ 2,500
African American Mental Health Center MS 22 099 03 003	Grant for African American Mental Health service providers that are licensed community mental health centers specializing in services for African American children and families.	-	$ 1,000		-
Mental Health Urgency Room Pilot MS 22 099 03 012	Pilot project that addresses emergency mental health needs. Urgency rooms are to be used as a first contact resource for youth under the age of 26 who are experiencing a mental health crisis.	-	$ 1,000	-	-
School Linked Mental Health Grants MS 22 099 03 018	$2,000,000 per year was appropriated in the 2022 legislative session for school-linked behavioral health grants under Minnesota Statutes, section 245.4901.	-	$ 2,000	$ 2,000	$ 2,000
Lower Level of Care - Discharge Planning MS 22 099 03 014	Provides a person centered discharge planning process for adults and children being discharged from psychiatric residential treatment facilities.	-	$ 250	$ 250	$ 250

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Program Name Federal or State or Both (citation)	Purpose/ Recipient Type(s) Eligibility Criteria	FY 2022	FY 2023	FY 2024	FY 2025
Children's First Psychosis Grant - Rider MS 22 099 03 004	Funding to implement a children's first episode of psychosis grant under Minnesota Statutes section 245.4905.	-	$ 6	$ 361	$ 361
Aid to Tribes and Counties-Fraud Prevention Grants (FPG) 256.983	Grants to tribes and counties for the Fraud Prevention Investigation Program, enabling early fraud detection and collection efforts.	$ 425	$ 850	$ 850	$ 850