Minnesota Department of **Human Services**

January 25, 2005

To the 2005 Minnesota Legislature:

On behalf of Governor Tim Pawlenty, I am submitting the Department of Human Services' recommendation for the 2006-07 biennial budget. Our proposed expenditures are $7.8 billion (General Fund) or $19.7 billion when all funds are included.

Human Services currently makes up 25% of state general fund spending, and 34% of all-funds spending. The rate of growth the department is experiencing makes it necessary to reduce some services to keep our spending from consuming an even larger portion of the state budget, thereby shortchanging other important priorities. However necessary, making reductions in human services is never easy. Because our mission is to help low-income people meet their basic needs, virtually any reduction in our budget represents the loss of a service someone finds important to their daily lives.

With that tension in mind, our goals in developing our budget were to meet statutory obligations, preserve core services for the most vulnerable people, make investments in key areas and reduce our rate of spending growth. Our decisions were based on the following principles:

- Statutory requirements, including public safety and treatment obligations under the Commitment Act will be met.
- Vulnerable children will be protected.
- Growth in costs will be reduced.
- Program integrity, customer service, and health outcomes for enrollees will be improved to better address health care costs into the future.
- Selected new programs will be delayed.

Thank you for your thoughtful consideration of our budget. We look forward to discussing these proposals in the months ahead.

Sincerely,

Kevin P. Goodno

Kevin Goodno
Commissioner

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	3,301,811	3,561,155	3,561,155	3,561,155	7,122,310
Recommended	**3,301,811**	**3,524,869**	**3,804,964**	**3,976,829**	**7,781,793**
Change		(36,286)	243,809	415,674	659,483
% Biennial Change from 2004-05					14%
State Government Spec Revenue					
Current Appropriation	534	534	534	534	1,068
Recommended	**534**	**534**	**534**	**534**	**1,068**
Change		0	0	0	0
% Biennial Change from 2004-05					0%
Health Care Access					
Current Appropriation	273,722	302,272	302,272	302,272	604,544
Recommended	**273,722**	**257,741**	**490,748**	**559,856**	**1,050,604**
Change		(44,531)	188,476	257,584	446,060
% Biennial Change from 2004-05					97.7%
Federal Tanf					
Current Appropriation	270,175	277,515	267,227	267,227	534,454
Recommended	**270,175**	**267,227**	**283,567**	**280,959**	**564,526**
Change		(10,288)	16,340	13,732	30,072
% Biennial Change from 2004-05					5%
Lottery Cash Flow					
Current Appropriation	1,556	1,556	1,556	1,556	3,112
Recommended	**1,556**	**1,556**	**1,456**	**1,456**	**2,912**
Change		0	(100)	(100)	(200)
% Biennial Change from 2004-05					-6.4%
Expenditures by Fund					
Direct Appropriations					
General	3,358,704	3,562,443	3,804,964	3,976,829	7,781,793
State Government Spec Revenue	486	582	534	534	1,068
Health Care Access	312,137	255,386	490,748	559,856	1,050,604
Federal Tanf	254,787	267,291	283,567	280,959	564,526
Lottery Cash Flow	1,527	1,585	1,456	1,456	2,912
Open Appropriations					
Special Revenue	352	667	340	340	680
Statutory Appropriations					
General	37,981	60,724	59,290	59,037	118,327
Health Care Access	0	27,992	26,491	31,386	57,877
Special Revenue	237,521	291,047	146,643	151,106	297,749
Federal	3,751,869	3,734,189	3,899,164	4,072,690	7,971,854
Miscellaneous Agency	606,773	813,237	813,135	813,134	1,626,269
Gift	25	87	75	75	150
Endowment	1	1	1	1	2
Mn State Operated Comm Svcs	67,342	68,258	68,258	68,258	136,516
Mn Neurorehab Hospital Brainer	16,050	18,717	18,717	18,717	37,434
Dhs Chemical Dependency Servs	18,296	18,030	18,030	18,030	36,060
Total	**8,663,851**	**9,120,236**	**9,631,413**	**10,052,408**	**19,683,821**

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Expenditures by Category					
Total Compensation	374,589	382,496	394,596	386,423	781,019
Other Operating Expenses	279,079	363,512	295,182	301,275	596,457
Payments To Individuals	6,531,120	6,837,933	7,404,438	7,822,408	15,226,846
Local Assistance	868,784	900,642	899,079	904,259	1,803,338
Other Financial Transactions	610,279	635,653	634,344	634,512	1,268,856
Transfers	0	0	3,774	3,531	7,305
Total	**8,663,851**	**9,120,236**	**9,631,413**	**10,052,408**	**19,683,821**
Expenditures by Program					
Agency Management	47,031	71,890	66,694	66,082	132,776
Revenue & Pass Through	988,734	1,192,957	1,184,236	1,185,011	2,369,247
Children & Economic Asst Gr	1,104,636	1,127,041	1,112,064	1,130,169	2,242,233
Children & Economic Asst Mgmt	85,431	101,407	100,115	101,143	201,258
Health Care Grants	3,268,873	3,288,979	3,727,833	3,995,803	7,723,636
Health Care Management	71,178	94,724	70,878	70,907	141,785
Continuing Care Grants	2,764,928	2,875,171	3,012,878	3,152,102	6,164,980
Continuing Care Management	32,026	40,356	34,313	34,527	68,840
State Operated Services	301,014	327,711	322,402	316,664	639,066
Total	**8,663,851**	**9,120,236**	**9,631,413**	**10,052,408**	**19,683,821**
Full-Time Equivalents (FTE)	**6,088.6**	**6,113.8**	**6,021.8**	**5,950.9**	

Dollars in Thousands

	FY2005	Governor's Recomm. FY2006	Governor's Recomm. FY2007	Biennium 2006-07
Fund: GENERAL				
FY 2005 Appropriations	**3,561,155**	**3,561,155**	**3,561,155**	**7,122,310**
Technical Adjustments				
Current Law Base Change		45,242	45,445	90,687
End-of-session Estimate		252,492	534,267	786,759
Fund Changes/consolidation		603	603	1,206
November Forecast Adjustment	(36,286)	102,994	197,007	300,001
Program/agency Sunset		(694)	(694)	(1,388)
Transfers Between Agencies		121,136	129,142	250,278
Subtotal - Forecast Base	**3,524,869**	**4,082,928**	**4,466,925**	**8,549,853**
Change Items				
Facilities Consolidation Lease Costs	0	4,537	4,767	9,304
Licensing Requirements	0	1,212	1,036	2,248
Fair Hearing Requirements	0	1,013	842	1,855
American Indian Child Welfare Project	0	0	4,838	4,838
Adoption Assistance & RCA Approp. Adj.	0	(1,340)	(1,491)	(2,831)
Prevent Homelessness After FC	0	1,157	1,151	2,308
Supp Housing Serv for Homeless	0	5,000	5,000	10,000
Delay Proj of Reg'l Significance	0	(25,000)	(25,000)	(50,000)
Freeze Max Child Care Rates	0	(33,351)	(37,214)	(70,565)
MDE Transfer Accounting Solutions	0	4,142	4,142	8,284
Finalize 2003 TANF Refinancing	0	(6,692)	(3,192)	(9,884)
Medicare Modernization Act Changes	0	(2,952)	(9,906)	(12,858)
Pharmaceutical Purchasing	0	(7,938)	(6,141)	(14,079)
Hospital Rate Reduction	0	(16,069)	(35,978)	(52,047)
Restructure MHCP Eligibility	0	51,377	43,840	95,217
Better Manage Health Care Costs	0	2,101	(350)	1,751
Refinance Health Care Programs	0	(259,823)	(420,338)	(680,161)
NF Quality and Rate Reform	0	(236)	(1,360)	(1,596)
Manage Waiver Caseload Growth	0	(13,372)	(38,074)	(51,446)
SOS Forensics Services Util.	0	17,731	19,797	37,528
Improve Mental Health Coverage	0	239	3,235	3,474
Methamphetamine Treatment	0	300	300	600
Total Governor's Recommendations	**3,524,869**	**3,804,964**	**3,976,829**	**7,781,793**
Fund: STATE GOVERNMENT SPEC REVENUE				
FY 2005 Appropriations	**534**	**534**	**534**	**1,068**
Subtotal - Forecast Base	**534**	**534**	**534**	**1,068**
Total Governor's Recommendations	**534**	**534**	**534**	**1,068**
Fund: HEALTH CARE ACCESS				
FY 2005 Appropriations	**302,272**	**302,272**	**302,272**	**604,544**
Technical Adjustments				
Current Law Base Change		(28)	(28)	(56)
End-of-session Estimate		64,706	97,884	162,590
November Forecast Adjustment	(44,531)	(61,132)	(164,336)	(225,468)
Subtotal - Forecast Base	**257,741**	**305,818**	**235,792**	**541,610**
Change Items				
Facilities Consolidation Lease Costs	0	1,396	1,443	2,839
Hospital Rate Reduction	0	(1,312)	(2,430)	(3,742)
Restructure MHCP Eligibility	0	(77,923)	(97,331)	(175,254)
Better Manage Health Care Costs	0	2,946	2,044	4,990
Refinance Health Care Programs	0	259,823	420,338	680,161
Total Governor's Recommendations	**257,741**	**490,748**	**559,856**	**1,050,604**
Fund: FEDERAL TANF				

Dollars in Thousands

	FY2005	Governor's Recomm. FY2006	Governor's Recomm. FY2007	Biennium 2006-07
FY 2005 Appropriations	**277,515**	**267,227**	**267,227**	**534,454**
Technical Adjustments				
Current Law Base Change		3,468	6	3,474
End-of-session Estimate		4,045	(1,404)	2,641
November Forecast Adjustment	(10,288)	8,827	15,130	23,957
Subtotal - Forecast Base	**267,227**	**283,567**	**280,959**	**564,526**
Total Governor's Recommendations	**267,227**	**283,567**	**280,959**	**564,526**
Fund: LOTTERY CASH FLOW				
FY 2005 Appropriations	**1,556**	**1,556**	**1,556**	**3,112**
Technical Adjustments				
Current Law Base Change		(100)	(100)	(200)
Subtotal - Forecast Base	**1,556**	**1,456**	**1,456**	**2,912**
Total Governor's Recommendations	**1,556**	**1,456**	**1,456**	**2,912**
Fund: SPECIAL REVENUE				
Planned Open Spending	**667**	**340**	**340**	**680**
Total Governor's Recommendations	**667**	**340**	**340**	**680**
Fund: GENERAL				
Planned Statutory Spending	**60,724**	**59,290**	**59,037**	**118,327**
Total Governor's Recommendations	**60,724**	**59,290**	**59,037**	**118,327**
Fund: HEALTH CARE ACCESS				
Planned Statutory Spending	**27,992**	**26,491**	**31,386**	**57,877**
Total Governor's Recommendations	**27,992**	**26,491**	**31,386**	**57,877**
Fund: SPECIAL REVENUE				
Planned Statutory Spending	**291,047**	**146,476**	**150,939**	**297,415**
Change Items				
Licensing Requirements	0	167	167	334
Total Governor's Recommendations	**291,047**	**146,643**	**151,106**	**297,749**
Fund: FEDERAL				
Planned Statutory Spending	**3,734,189**	**3,899,164**	**4,072,690**	**7,971,854**
Total Governor's Recommendations	**3,734,189**	**3,899,164**	**4,072,690**	**7,971,854**
Fund: MISCELLANEOUS AGENCY				
Planned Statutory Spending	**813,237**	**813,135**	**813,134**	**1,626,269**
Total Governor's Recommendations	**813,237**	**813,135**	**813,134**	**1,626,269**
Fund: GIFT				
Planned Statutory Spending	**87**	**75**	**75**	**150**
Total Governor's Recommendations	**87**	**75**	**75**	**150**
Fund: ENDOWMENT				
Planned Statutory Spending	**1**	**1**	**1**	**2**
Total Governor's Recommendations	**1**	**1**	**1**	**2**
Fund: MN STATE OPERATED COMM SVCS				
Planned Statutory Spending	**68,258**	**68,258**	**68,258**	**136,516**
Total Governor's Recommendations	**68,258**	**68,258**	**68,258**	**136,516**
Fund: MN NEUROREHAB HOSPITAL BRAINER				
Planned Statutory Spending	**18,717**	**18,717**	**18,717**	**37,434**
Total Governor's Recommendations	**18,717**	**18,717**	**18,717**	**37,434**

Dollars in Thousands

	FY2005	Governor's Recomm. FY2006	Governor's Recomm. FY2007	Biennium 2006-07
Fund: DHS CHEMICAL DEPENDENCY SERVS				
Planned Statutory Spending	**18,030**	**18,030**	**18,030**	**36,060**
Total Governor's Recommendations	**18,030**	**18,030**	**18,030**	**36,060**
Revenue Change Items				
Fund: GENERAL				
Change Items				
Facilities Consolidation Lease Costs	0	1,243	1,312	2,555
Licensing Requirements	0	887	772	1,659
Fair Hearing Requirements	0	405	337	742
Prevent Homelessness After FC	0	32	29	61
MDE Transfer Accounting Solutions	0	4,142	4,142	8,284
Medicare Modernization Act Changes	0	422	717	1,139
Better Manage Health Care Costs	0	1,552	1,657	3,209
Refinance Health Care Programs	0	0	(112,878)	(112,878)
SOS Forensics Services Util.	0	1,773	1,980	3,753
Improve Mental Health Coverage	0	34	34	68
Finalize 2003 TANF Refinancing	0	(6,692)	(3,192)	(9,884)
Fund: HEALTH CARE ACCESS				
Change Items				
Facilities Consolidation Lease Costs	0	559	577	1,136
Restructure MHCP Eligibility	0	174	0	174
Better Manage Health Care Costs	0	1,173	840	2,013
Refinance Health Care Programs	0	0	112,878	112,878
Fund: SPECIAL REVENUE				
Change Items				
Licensing Requirements	0	167	167	334

Fiscal Impact ($000s)	FY 2006	FY 2007	FY 2008	FY 2009
General Fund				
Expenditures	$4,537	$4,767	$4,767	$4,767
Revenues	1,243	1,312	1,312	1,312
Health Care Access Fund				
Expenditures	1,396	1,443	1,443	1,443
Revenues	559	577	577	577
Net Fiscal Impact	$4,131	$4,321	$4,321	$4,321

Recommendation

The Governor recommends an increased appropriation to the Department of Human Services to cover the increased lease costs associated with the consolidation of nine metro locations into three.

Background

The Department of Human Services is consolidating office space from nine current metro locations into three – a new building at 540 Cedar Street (Andersen Human Services Building), a leased facility at 444 Lafayette (Lafayette building), and the Department's operations center in Lafayette Park.

The rent rate for the Andersen Human Services Building will be higher than the current negotiated rates on other DHS facilities. The rate is estimated to be $34.34 per square foot; for comparison, the current rate on the Lafayette building is $22.23 per square foot. However, the state will have the option of purchasing the building for $1 at the end of the 25-year lease. As a result of this lease-purchase option, an analysis conducted prior to the start of the project determined that the overall cost to the state will be lower than it would otherwise be in the long term. Like other General Fund expenditures, federal reimbursement reduces the cost of the overall proposal.

Although the relocation of staff will be done in a rapid and carefully coordinated phased move into both the Andersen and Lafayette buildings, the Department will experience some double-rent costs during the transition period.

This proposal would increase the funding to the Department to address this increase in lease costs.

Key Measures

Please see http://www.departmentresults.state.mn.us/hs/index.html for a listing of Department measures.

Statutory Change: Not Applicable.

Fiscal Impact ($000s)	FY 2006	FY 2007	FY 2008	FY 2009
General Fund				
Expenditures	$1,212	$1,036	$1,036	$1,036
Revenues	887	772	772	772
Special Revenue				
Expenditures	167	167	167	167
Revenues	167	167	167	167
Net Fiscal Impact	$325	$264	$264	$264

Recommendation

The Governor recommends an increase to fees and appropriations to:

⇒ Meet current statutory performance requirements for licensing and maltreatment investigations.

⇒ Implement improved licensing oversight of residential services for children in out-of-home placements (known as the "umbrella rule"), effective 7-1-05.

⇒ Address increased costs of conducting background studies.

Background

Licensing Performance Standards

Current program. In cooperation with counties, the Department licenses approximately 27,000 providers, and monitors and investigates their compliance with Minnesota laws and rules. The purpose of licensing is to protect the health, safety and rights of those receiving services by requiring that providers meet minimum standards of care and physical environment.

⇒ Counties have primary responsibility for monitoring *family* child care, child foster care and adult foster care programs (approximately 23,000 programs).

⇒ The Department has full responsibility for licensing child care *centers*; adolescent group homes; and residential, outpatient and day training treatment programs for people with chemical dependency, mental health problems or developmental disabilities (approximately 4,000 programs).

Licensors conduct license inspections for new and existing programs, monitor compliance with license requirements, process variances to licensing rules, conduct complaint investigations and provide limited technical assistance. When problems are found, licensors may issue correction orders and fines or place a program's license on conditional status or suspend or revoke a license.

Each year, the Department also investigates about 700 allegations of maltreatment of children or vulnerable adults in licensed programs.

See http://www.budget.state.mn.us/budget/operating/200607/background2/humanservices.pdf for further information about licensing activities conducted by the department.

State statute requires that licensing activities be completed within the timelines listed in the Key Measures section below. The Department continues to gain efficiencies through reorganization of workflow and increased use of technology; however, in some cases statutory regulations have not been met.

Proposal details. In order to meet the statutory requirements for licensing performance, this proposal would:

⇒ Increase the Department's staff levels by 13 full-time equivalents.

⇒ Restructure license fees for home and community-based services (waiver) providers to increase revenues by approximately $292,000 per year by establishing a base rate of $250 per license plus $38 per client served. (There are currently approximately 876 licenses and 11,245 clients served). The current license fee is $400

per license regardless of the number of clients served by the license holder. This fee currently generates approximately $348,000 per year;

⇒ Lower license fees for license-holders serving three or few clients. (For example, a license-holder serving one client would have a license fee of $288 ($250 + $38) instead of $400). Those serving more than four clients would have higher license fees. (For example, a program serving 10 clients would have a license fee of $630 instead of the flat rate of $400.)

Umbrella Rule Implementation

Current program. In addition to conducting licensing activities under current standards, the Department is required to implement changes to regulatory oversight of residential services for children in out-of-home placement beginning 7-1-05.

Children placed in residential facilities often require an array of services such as transitional services, chemical dependency and mental health treatment, and correctional services, to address multiple issues. Because only one service may be licensed per program under current state rules, the 1995 Legislature directed DHS and DOC to jointly develop one set of consistent licensing standards for all residential services for children in out-of-home placement (referred to as the Umbrella Rule).

The two Departments jointly promulgated rules governing the licensure and certification of residential treatment and detention facilities and foster homes for children and juveniles (Minnesota Rules, chapter 2960). Chapter 2960 replaces five human services' and four corrections' rules and creates a new certification category for programs that offer transitional services. The rule also establishes standards for foster homes that offer treatment foster care.

When fully implemented, the new rule will affect approximately 5,500 providers who serve approximately 17,500 children on an average daily basis. The umbrella rule increases the likelihood that children will be placed in the most appropriate residential setting regardless of their entry point into the system. Children's needs will be addressed across the full continuum of services ranging from foster care in a family setting to environments with much greater structure, including security or treatment services provided on site. Some of the regulated on-site services will include treatment for chemical dependency or mental health, behavior therapy for sexual offenders with predatory behavior, or any combination of these services.

The child foster care component was implemented effective 1-1-04. The remainder of the rule was delayed until 7-1-05, so that the issue of administrative resources for implementation could be addressed as part of the budget planning cycle.

The new rule impacts the Department workload in the following manner:

⇒ The survey time, education, and technical assistance for the 68 programs DHS already licenses will double under the new rule.

⇒ 50 programs that are currently licensed by DOC will also require DHS certification to provide mental health treatment services (35 programs) or chemical dependency treatment services (15 programs). The jurisdiction for investigating child maltreatment in these 50 programs will shift from counties to DHS.

⇒ Five programs that are currently licensed by DHS will require additional DHS certification to provide chemical dependency treatment services.

The Department is not able to implement the new umbrella rule with current staffing levels without further exacerbating the issue of the agency's performance of current licensing functions and maltreatment investigations.

Proposal details. To implement the umbrella rule, this proposal would increase the Department's staff levels by two full-time equivalents.

Background Study Costs

Current program. In addition to licensing, the Department conducts about 167,000 background studies each year on people having direct contact with children or vulnerable adults as providers licensed by the Minnesota Departments of Human Services, Corrections and Health as well as specified non-licensed providers. These background studies are intended to prevent people with serious criminal records or records of maltreatment of children or vulnerable adults from working in licensed programs.

M.S. 245C.03 requires the Commissioner to conduct background studies on non-licensed personal care provider organizations (PCPOs) and supplemental nursing services agencies (SNSAs). M.S. 524.5-118 requires the Commissioner to conduct background studies on court-appointed guardians. In FY 2004 10,279 studies were completed for PCPOs; 5,345 studies for SNSAs; and 2,559 studies for court-appointed guardians. The remainder of background studies are conducted for providers licensed by the Minnesota Departments of Human Services, Corrections and Health.

The Human Services Background Study Act provides for comprehensive services to background-study customers. The study includes Bureau of Criminal Apprehension (BCA) records; Federal Bureau of Investigation (FBI) records when indicated; a review of substantiated maltreatment of children and vulnerable adults as determined by the DHS, MDH, and all 87 county adult-protection agencies. When indicated, the Department also pursues criminal records and maltreatment findings in other states. The Department maintains a data base to ensure information is taken into account about any current maltreatment investigation, as well as any history of set asides or variances

The Department makes disqualification decisions and offers an extensive system of due process to affected parties. There is no cost to the study subject for reconsiderations, fair hearings, or contested case hearings.

The current fees for background studies for PCPO, SNSA, and court appointed guardian background studies are no longer adequate to cover the direct and in-direct costs of conducting these comprehensive studies. The amount of the fee for background studies completed for SNSAs and PCPOs is set forth in M.S. 245C.1, as $8 and $12 per study, and the amount for court-appointed guardians is set forth in M.S. 245A.32 as $12.

The BCA charges $15 for a full-criminal-history record that contains public and private criminal history information and makes some public criminal history information available through the BCA web-site for $5. The background study services provided by the department are more comprehensive.

Proposal details. This proposal would increase the fee to $20 per background study for non-licensed entities required to have a background study completed by the department. The increase in fees would address expenses of conducting background studies and assist in advancing the technology necessary to expand web-based applications to provide faster services. The average *direct* cost per background study is $14.82, based on 21,000 background studies (and 450 subsequent fingerprints). The fee increase would also cover the *indirect* costs to the state's General Fund.

Key Measures

- Investigations of licensing complaints completed within an average of 75 days.
- Licensing reviews completed within the one-year and two-year intervals set forth in statute.
- Negative licensing action decisions completed within 45 days of county recommendations.
- Maltreatment investigations completed within 60 days.
- Timely completion of background study requests.

Statutory Change: M.S. §245A.10, subd. 5; §245C.10 and §245C.32, subd. 2

Change Item: Meeting Statutory Requirements for Administrative Fair Hearings

Fiscal Impact ($000s)	FY 2006	FY 2007	FY 2008	FY 2009
General Fund				
Expenditures	$1,013	$842	$842	$842
Revenues	405	337	337	337
Net Fiscal Impact	$608	$505	$505	$505

Recommendation

The Governor recommends an increased appropriation to meet federal and state requirements pertaining to the provision of administrative fair hearings for applicants or recipients of human services benefits.

Background

The human services appeals process is a mechanism by which an applicant for or recipient of various forms of human services benefits may obtain impartial review of specified adverse or negative decisions affecting those benefits. The foundation for this process is the case of *Goldberg v. Kelly*, in which the court concluded that procedural due-process required the opportunity to seek a hearing before a state could terminate one's benefits. To formally incorporate the requirements of *Goldberg*, the Minnesota Legislature enacted M.S. 256.045 in 1976. This provides for an adjudicatory system in which appeals referees conduct evidentiary hearings and make recommended decisions to the Commissioner of Human Services. See http://www.budget.state.mn.us/budget/operating/200607/background2/humanservices.pdf for further information about administrative fair hearings conducted by the Department.

Initially the hearings were limited to a review of denials of new applications for assistance, reductions or terminations of ongoing payments, and determinations that past benefits were incorrectly paid in a rather narrow range of public assistance programs. Over the years, however, the powers of the appeals process have been expanded to include review of the nature, level and quality of social services, and determinations that one has maltreated a child or vulnerable adult.

In 2003 M.S. 256.045 was augmented by enacting M.S. 256.045. This is a comprehensive set of procedural rules governing all aspects of the appeals process.

In 2003 the number of appeals to the Department began to rise dramatically to nearly 500 per month, an increase of over 40%. This elevated number of appeals has continued in 2004, and there is no indication that the number of appeals will drop. In recent years the focus of appeals has evolved from simple, single issue questions of eligibility to multifaceted inquiries into people's medical and social services needs. In addition, the appeals function now reviews determinations of maltreatment of children and vulnerable adults and these generally are protracted hearings.

The increased number and complexity of appeals has caused a substantial reduction in the compliance rates for timely issuance of decisions, from 95% timely to less than 70% timely.

Untimely decisions are a problem for a number of reasons:

- They violate federal and state law.
- They expose the Department to potential federal fiscal sanctions.
- They expose the state to potential litigation.
- In some cases the delay results in delayed receipt of benefits by someone who is entitled to the benefits; and conversely in some cases a delay results in an individual continuing to receive benefits beyond the time where they are eligible to receive those benefits.
- Delays erode clients' confidence in the human service delivery system in general, as well as their confidence in the fairness of the appeals process itself.

The appeals function currently has 14 appeals referees, a chief appeals referee and four clerical support staff. Funding for two of the referee positions will end on 6-30-05.

Generally one referee can meet established timelines 95% of the time if the referee has an assigned caseload of 25 appeals per month or 300 appeals annually. With this caseload, the referee has an average of 6.9 hours per appeal. At the present time 14 referees are each attempting to manage a caseload of 39 appeals per month or 470 appeals annually. With this caseload, the referee is limited to an average 4.4 hours per appeal. This overload has led to decreased timeliness in issuing decisions.

Additional resources are required to enable this function to meet federal and state requirements for fair hearings.

Proposal Details
This proposal would increase the Department's base-funding staff level by eight referees and three clerical support staff to enable the human service appeals function to meet federal and state requirements for fair hearings. (Due to the termination of funding for two referee positions on 6-30-05, this is an increase of only six referees over FY 2005 funding levels.)

Key Measures
Compliance with state and federal timelines for appeals decisions.

Alternatives Considered
An alternative to increasing department funding to address this issue would be to move this function to the Office of Administrative Hearings (OAH). The fiscal impact would be significant, as OAH would bill the agency $135 per hour for administrative law judges and $74 per hour for staff attorneys. Based on the department's licensing appeals currently handled by OAH, the average cost per appeal would be close to $5,000. (90 cases disposed of in FY 2004, at a total cost of $436,677).

Statutory Change: Not Applicable

Fiscal Impact ($000s)	FY 2006	FY 2007	FY 2008	FY 2009
General Fund Expenditures	0	$4,838	$4,838	$4,838
Net Fiscal Impact	0	$4,838	$4,838	$4,838

Recommendation

The Governor recommends an appropriation for a project that would enable up to two tribes to provide the full continuum of child welfare services to American Indian children living on the participating tribe's reservations.

Background

Current Program

American Indian children are greatly over-represented in out-of-home placements. In 2003, approximately 1,000 American Indian children from one of the 11 tribes with reservations in Minnesota were alleged to have been abused or neglected; 48% of those were determined to be abused or neglected. During this same time period, over 1,300 American Indian children were served in out-of-home care. American Indian children are six times more likely than other children to be removed from their home.

The costs for out-of-home placement *alone* for White Earth and Leech Lake are estimated to exceed $4 million in county and federal dollars each year. This is in addition to other child welfare costs such as prevention, assessment, and family preservation.

Tensions between some tribes and counties regarding authority, obligations and funding capacity inhibit the best provision of service to these children. The Department would provide fiscal and technical support to up to two participating tribal bands to increase their capacity to provide child welfare services to enrolled members on the reservation. This proposal would relieve counties in the project area of a significant financial burden and allow greater self-determination for tribes regarding the welfare of Indian children.

Proposal Details

The tribal band would enter into an agreement to provide the full continuum of child welfare services, including family preservation, early intervention, support services, and out-of-home care, and would provide assurances of compliance with federal and state law regarding child welfare. At the same time, affected counties would be relieved of the same responsibilities for the population affected.

The Department would provide the non-federal share of resources for child welfare services provided to enrolled members on the reservation and pass through appropriate federal funds.

The proposal is expected to increase the provision of more culturally appropriate services, reduce county-tribal disagreements and tensions, and enhance tribal strengths and resources in a manner that improves outcomes for children. The Department would study outcomes related to child safety, permanency and well-being for American Indian children of the participating tribes.

The fiscal impact is based on estimates for White Earth and Leech Lake Tribes for the full continuum of child welfare services. Actual costs will vary depending on the sites selected for the project. If the Department receives federal approval of the Tribal-State IV-E agreement, state costs would be reduced by approximately one-third.

Key Measures

⇒ Percent of children who do not experience repeated neglect or abuse within 12 months of prior report.
⇒ Percent of children entering foster care without a prior out-of-home placement in the previous 12 months.
⇒ Percent of children reunified in less than 12 months from the time of the latest removal from their home.

Please see http://www.departmentresults.state.mn.us/hs/index.html for a report on the status of these measures.

Statutory Change: M.S. 256.01, subd. 14

Change Item: Adjust Appropriation for Adoption Assistance & Relative Custody Assistance

Fiscal Impact ($000s)	FY 2006	FY 2007	FY 2008	FY 2009
General Fund				
Expenditures	($1,340)	($1,491)	$1,500	$4,508
Net Fiscal Impact	($1,340)	($1,491)	$1,500	$4,508

Recommendation

The Governor recommends that the appropriation for Adoption Assistance and Relative Custody Assistance be adjusted to align with projected expenditures. The most recent projections for the FY2006-07 biennium show slower growth in these two programs than was previously expected.

Background

Current Program

There are approximately 1,500 children under state guardianship. Close to 700 children per year experience a termination of parental rights and are in need of adoption. Another 400 children per year experience a transfer of permanent legal and physical custody to a relative or person significant to the child.

Some adoptive parents and legal custodians assume parenting responsibility for children who have experienced serious neglect and often emotional or physical abuse. Many of these children have additional neurological or medical issues and often require psychological, medical, educational, and social services. Parents adopting these children have difficulty meeting the special needs without financial and other supports. If parents were not willing to make these children part of their family, many of the children would continue to be wards of the state, and counties would continue to pay for foster care.

⇒ **Adoption Assistance (AA)**. The AA Program provides financial assistance to adoptive parents to purchase ongoing and specialized services integral to addressing the special needs of a child described above. The AA caseload is changing primarily as a function of the number of children with special needs who have been committed to state guardianship and the state and county success in finding and supporting adoptive families. For 80% of these children, federal Title IV-E funding covers half of the assistance.

⇒ **Relative Custody Assistance (RCA).** Similar to AA, RCA provides monthly financial assistance to a relative or person-significant-to-the-child who accepts permanent legal and physical custody, except that the monthly payment is adjusted based on the relative custodian's gross family income. The juvenile court must first determine that it is in the child's best interests to transfer permanent legal and physical custody rather than terminate parental rights. Thus, there is little or no difference in the needs of children experiencing a transfer of permanent legal and physical custody in comparison to those experiencing a termination of parental rights. RCA is funded entirely with state dollars.

There is a high degree of interactivity among foster care, adoption assistance, and relative custody assistance. Children reside in foster care and other residential treatment facilities during family reunification efforts. The primary permanency options for children who cannot return home are adoption or transfer of permanent legal and physical custody. See http://www.budget.state.mn.us/budget/operating/200607/background2/humanservices.pdf for further information about these programs.

Proposal Details

This proposal would maintain services by adjusting the appropriation for AA-RCA to align with the projected utilization of the program: a reduction in FYs 2006-07 and an increase in FYs 2008-09.

Key Measures

- Percentage of children adopted in fewer than 24 months from the time of latest removal from their home.

See http://www.departmentresults.state.mn.us/hs/index.html for a current report on the status of these measures.

Statutory Change: Not applicable.

Change Item: Prevent Homelessness for Young Adults Transitioning from Long-term Foster Care

Fiscal Impact ($000s)	FY 2006	FY 2007	FY 2008	FY 2009
General Fund				
Expenditures	$1,157	$1,151	$1,151	$1,151
Revenues	32	29	29	29
Net Fiscal Impact	$1,125	$1,122	$1,122	$1,122

Recommendation

The Governor proposes an appropriation for a partnership to help transition and prevent homelessness for older youth as they leave long-term foster care.

Background

Current Program

In 2003, approximately 1,200 youth over age 16 were either wards of the state or had a permanency disposition of long term foster care. More than half of these youth had a disability that further impaired their ability to achieve and sustain housing. These youth age out of the foster care system when they turn 18 and complete their senior year of high school; and the degree to which they are prepared to live independently varies greatly across the state.

According to the Wilder Research Center, in 2003 there were between 500 and 600 homeless youth in Minnesota. Seventy percent of these homeless youth have experienced a placement in a foster home, group home or corrections facility. Forty-one percent of homeless adults report that they have a physical, mental or other health condition that limited the kind or amount of work they could do.

Youth who are prepared and supported in their transition toward adulthood are more likely to achieve and sustain economic self-sufficiency and less likely to depend on public services in the longer term.

Programs to assist youth are not available statewide. County social service agencies lack the capacity to provide comprehensive transition planning and services to assure that all youth exiting foster care --and especially those with a disability-- are equipped with the skills to successfully transition to independent living.

This proposal is based on the development of a partnership involving public, business, and philanthropic resources to assist in transitioning older youth from foster care and reducing their risk of homelessness.

The proposal would include a comprehensive assessment of youth in transition; development and implementation of an independent living plan for the individual that would utilize the strengths and resources of all of the partners. Youth would be taught life skills such as money management, securing and maintaining housing, health management and job training. Youth would be connected with caring adults to teach them skills and to support their development and transition to adulthood. Youth would be given opportunities to pursue post-secondary education or employment.

In coordination with the resources of other partners, this proposal would:

- Support transitional planning targeted to youth in foster care who are ages 16 and older and have a disability.
- Provide housing assistance to an estimated 140 youth who exit foster care each year and are age 18 to 21.
- This proposal would provide one full-time-equivalent employee to the Department to administer and coordinate these projects.

The Department would request proposals from vendors who would partner with counties and assist these at-risk 16 to 21 year-olds in establishing an independent living plan with housing support.

Change Item: Prevent Homelessness for Young Adults Transitioning from Long-term Foster Care

Key Measures

Performance will be measured by the number of youth that complete an assessment and transition plan, obtain a high school degree, participate in a work/training program, enroll in a post-secondary educational setting and are established in housing.

Statutory Change: Not Applicable

Change Item: Address Homelessness with Supportive Housing Service Grants

Fiscal Impact ($000s)	FY 2006	FY 2007	FY 2008	FY 2009
General Fund Expenditures	$5,000	$5,000	$5,000	$5,000
Net Fiscal Impact	$5,000	$5,000	$5,000	$5,000

Recommendation

The Governor recommends providing flexible service funding to support the State's goal of ending long-term homelessness in Minnesota by 2010. This proposal would provide $5 million per year in flexible service funding to consortia of counties for supportive housing projects that address the needs of the long-term homeless.

Background

It is the State's goal to end long-term homelessness in Minnesota by 2010 by providing housing and support services to 4,000 individuals and families experiencing long-term homelessness. In 2003, the Minnesota Legislature, at the request of Governor Tim Pawlenty, directed the Commissioners of Human Services, Corrections, and Housing Finance to convene a broadly representative working group to address the issue of long-term homelessness in Minnesota. This group developed the Business Plan to End Long-Term Homelessness, which was made public in March 2004.

The key strategy for ending long-term homelessness, as outlined in the business plan, is to provide people experiencing long-term homelessness a permanent place to live, along with the support services they will need to remain successfully housed over the long term. According to a 2003 Wilder Survey, 52% of people experiencing long-term homelessness have a serious and persistent mental illness, 33% have a chemical dependency problem, 24% have a dual diagnosis of mental illness and chemical dependency addiction, and 48% have a chronic health condition. Services are needed to address these issues, many of which prevent people from being successfully housed.

Service funding is largely based on an individual's personal characteristics, such as age, disability and/or county of residence. A portion of people who experience long-term homelessness are not eligible for existing programs and, even for those who do qualify, these mainstream programs do not provide all the necessary supports to keep this population permanently housed. This gap creates numerous problems in both developing supportive housing and in assuring adequate funding for ongoing services. A flexible service fund would address these issues and is an essential component of achieving the State's goal to end long-term homelessness.

Regional and cooperative efforts would receive priority in order to provide seamless service delivery to eligible participants. Projects would need to leverage other funding as well as maximize the use of mainstream funding. The initiative is expected to fund a limited number of service proposals. These funds would be administered by the Department with the cooperation of the MN Housing Finance Agency (MHFA) through a competitive proposal process.

Counties would be expected to coordinate the service funding with supportive housing opportunities funded through MHFA.

http://www.mhfa.state.mn.us/about/about_reports.htm

Key Measures

- The number of supportive housing settings for long-term homelessness with associated service funding.

Statutory Change: Minn. Stat. 256K.25

Fiscal Impact ($000s)	FY 2006	FY 2007	FY 2008	FY 2009
General Fund Expenditures	($25,000)	($25,000)	0	0
Net Fiscal Impact	($25,000)	($25,000)	0	0

Recommendation

The Governor recommends a reduced appropriation to accompany a two-year delay in implementation of the projects of regional significance portion of the Children and Community Services Act grant program.

Background

The 2003 Legislature adopted a recommendation to consolidate funding for the Children and Community Services Act (CCSA), M.S., 256M.01 to 256M.80. The focus of the act is to support people who experience disparate treatment and poor outcomes due to factors such as dependency, abuse, neglect, poverty, disability and chronic health conditions. The act also provides services for family members to support those individuals.

The Legislature appropriated approximately $100 million per year for the consolidated fund --$25 million lower than earlier funding for related activities. Current law provides that the base funding level will be restored to approximately $125 million in FY 2006, designating the $25 million increase for implementation of projects of regional significance.

The projects of regional significance are intended to support and further trends in the development of human services capacity and service delivery on a regional basis.

This proposal would delay implementation of projects of regional significance to 7-1-07.

Statutory Change: M.S. 256M.40, Subd. 2

Change Item: Freeze Maximum Rates Paid for Child Care Assistance

Fiscal Impact ($000s)	FY 2006	FY 2007	FY 2008	FY 2009
General Fund Expenditures	($33,351)	($37,214)	($37,006)	($36,433)
Net Fiscal Impact	($33,351)	($37,214)	($37,006)	($36,433)

Recommendation

The Governor recommends extending the freeze on maximum rates paid to child care providers under the Child Care Assistance Program through June 30, 2007 and restricting growth in rates to a general inflation factor beginning July 1, 2007.

Background

The Department pays providers for child care provided to children whose families meet the eligibility requirements of the Child Care Assistance Program (CCAP) under Minnesota Families Investment Program (MFIP), including a transition year (TY), or Basic Sliding Fee Program (BSF). See http://www.budget.state.mn.us/budget/opreating200607/background2/humanservices.pdf for further information about these programs.

In 2003, state law changes re-focused eligibility for the child care program on lower income families and generated savings by limiting eligibility to families with incomes at or below 175% of the federal poverty guidelines (FPG) and continuing eligibility to families up to 250% of FPG, increasing family co-payments, and adjusting rates paid to providers. The maximum rates under CCAP were frozen for the FY 2004-05 biennium at the 2003 level. This proposal would continue to freeze rates paid to providers under the Child Care Assistance Program based on maximum payment rates that were set for 2003. Beginning in FY 2008, cost growth would be contained by setting maximum rates payable to providers on a general inflation factor using the Consumer Price Index (CPI). It is assumed that maximum rates in effect during SFY 2007 are the base for the increase based on the CPI beginning in FY 2008.

Because of its impact on state spending, this proposal would require changes to provisions defining the state's maintenance of effort necessary to access federal Temporary Assistance for Needy Families (TANF).

Statutory Change: M.S. 119B.13

Repeal 2003 First Special Session, Chapter 14, H.F. No. 6, Article 9, Section 34

Fiscal Impact ($000s)	FY 2006	FY 2007	FY 2008	FY 2009
General Fund				
Expenditures	$4,142	$4,142	$4,142	$4,142
Revenues	4,142	4,142	4,142	4,142
Net Fiscal Impact	0	0	0	0

Recommendation

The Governor recommends a technical budget neutral adjustment to appropriations and revenues for federal grants transferred from the Department of Education to make accounting for indirect costs consistent with standard statewide policy, and to simplify the financing of a small component of the Basic Sliding Fee Child Care Assistance Program (BSF).

Background

In 2003, several children and community support programs were transferred from the Department of Education to the Department of Human Services. This proposal seeks to provide budget neutral solutions to two accounting issues related to the transfer.

(1) Federal Grants: The Department of Education had permission from the Department of Finance to retain agency indirect costs on federal grants for agency operations. DHS's standard policy is to pay these costs to the general fund. This proposal would adjust appropriations and revenues so that indirect costs on these federal grants can be paid per standard policy.

(2) Child Care Child Support: Under current law, individuals receiving BSF child care assistance are required to assign their child care child support to the state to offset the costs of providing BSF child care assistance. Currently, these child care child support payments are accounted for in the Special Revenue Fund as dedicated revenue for the BSF program. Unnecessary administrative effort is required to account for this small revenue component of the BSF program. This proposal would repeal the Special Revenue account process and designate child care child support payments as non-dedicated revenue to the General Fund. The General Fund appropriation for the BSF program would be increased to offset the reduction in Special Revenue funds. This proposal would not change the assignment of child care child support for BSF recipients to the state, but would allow for more stable and timely BSF allocations to counties.

This proposal simplifies the Department's accounting process for federal grants transferred from MDE and simplifies the funding for a small component of the Basic Sliding Fee Program.

Statutory Change: M.S. Section 119B.074

Preliminary Proposal

Fiscal Impact ($000s)	FY 2006	FY 2007	FY 2008	FY 2009
General Fund				
Expenditures	$(6,692)	$(3,192)	$(3,192)	$(3,192)
Revenues	(6,692)	(3,192)	(3,192)	(3,192)
Net Fiscal Impact	0	0	0	0

Recommendation

The Governor recommends the refinancing of general fund spending with TANF funds to achieve general fund savings in FY2006 and FY2007 as adopted in 2003 Special Session Laws, Chapter 14 – the Omnibus Health and Human Services budget bill.

Background

Reductions in state funding for MFIP and child care programs in the 2003 session included undesignated refinancing of TANF funds starting in FY 2006. These were accounted for by designating TANF funds in the Revenue and Pass-through Budget Activity along with like amounts of undedicated revenue to the General Fund. This was done intentionally so that refinancing options could be considered at a later date and the best refinancing plan selected.

Under this proposed refinancing plan, general funds for MFIP Child Care would be reduced by $6,692,000 in fiscal year 2006 and $3,192,000 in fiscal year 2007 and beyond and replaced with a like TANF transfer to the Child Care and Development Fund (CCDF) that would be used to fund MFIP Child Care in FY 2006 and FY 2007 and beyond. This refinancing plan does not alter the forecasted nature of or eligibility criteria for MFIP Child Care.

The TANF Maintenance of Effort (MOE) requirement would not be met in FY 2006, therefore the allowance to use Working Family Credit as MOE would need to be increased by $6,692,000 in FY 2006. Further, the amount of Working Family Credit allowable for MOE in 2007 and 2008 would need to be increased by $3,192,000 to prevent an MOE deficit. The amount for 2009 would need to be increased by $1,367,000.

Statutory Change: Not Applicable.

Fiscal Impact ($000s)	FY 2006	FY 2007	FY 2008	FY 2009
General Fund				
Expenditures	($2,952)	($9,906)	($9,906)	($9,906)
Revenues	422	717	323	323
Net Fiscal Impact	($3,374)	($10,623)	($10,229)	($10,229)

Recommendation

The Governor recommends program and administrative changes to Medical Assistance and Prescription Drug Program associated with implementation of the new prescription drug benefit under Medicare Part D.

Background

Congress enacted the Medicare Modernization Act to cover a subsidized prescription drug benefit for Medicare beneficiaries.

In addition to qualifying for Medicare enrollment, many lower income Medicare beneficiaries meet the income and asset guidelines of state and federally funded Medicaid programs--known as Medical Assistance (MA) in Minnesota. As a result, some people may be dually enrolled in Medicare and:

- MA (known as full-benefit duals);
- Medicare Savings Programs such as Qualified Working Disabled (QWD), Qualified Medicare Beneficiary (QMB), Service Limited Medicare Beneficiary (SLMB), or Qualified Individuals (QI) programs; or
- Minnesota's state-funded pharmaceutical assistance program (SPAP), the Prescription Drug Program (PDP).

See http://www.budget.state.mn.us/buget/operating/200607/background2/humanservices.pdf for further information about these state programs.

Effective 1-1-06, federal match will no longer be available for MA payments for prescription medications that will be covered under Medicare Part D for people who are dually eligible for Medicare. Instead dual eligibles will obtain their prescription medications from Medicare Part D prescription drug plans or Medicare Advantage plans.

In addition to MA and Medicare Savings Programs enrollees, PDP enrollees will qualify for Medicare Part D. Differences between Medicare Part D and current prescription medication coverage for all of these populations may include:

- Medicare Part D coverage may impose co-payments and formulary limits that differ from MA and PDP and
- Medicare Part D does not provide retroactive coverage for medications, which MA does.

Because Medicare is the primary payer under the federal rules of the MA program, services that are available to an eligible beneficiary under Medicare cannot be matched by federal MA. However, state-only MA may continue to cover certain medications that are excluded from Medicare.

Until the federal regulations governing Medicare Part D are promulgated, and the Part D plans and their formularies are fully identified, the extent of these differences will not be clear. At this stage, however, the Department anticipates that the Medicare Part D benefit will be as good as the current benefit for most enrollees.

Final regulations on Medicare Part D have not been issued. While DHS will likely have a role in the Medicare Part D application and enrollment process, that role is not clear. Initially, it is expected that the Department will have minimal involvement in processing applications for Part D –with the Social Security Administration (SSA) being fully responsible for application processing and subsidy determinations. Once final regulations have been issued and the Department's new Web-based eligibility processing system for the state's publicly-funded health care programs is implemented, the Department's role will change.

The Minnesota Board on Aging projects that initially 98,000 people will seek information on Medicare Part D coverage and assistance enrolling and selecting an option that best meets their individual needs. People will contact the Board's 12 outreach sites and 7 call centers and are projected to require an average of 2 hours of assistance in the first year, tapering to 1 hour in subsequent periods. The current level of contacts is addressed by the Board with 45 paid full-time equivalents (FTEs) and approximately 200 volunteers. The substantial

increase in contacts will require a staffing increase of 45% supplemented with a 125% increase in the number of volunteers.

The Department will focus initial efforts on assisting current full-benefit dual-eligibles and PDP enrollees to enroll in Medicare Part D.

There are three components to this proposal:

⇒ First, the provision of information and enrollment assistance for people seeking to understand coverage under Medicare Part D, including selecting a plan that best meets their needs. This proposal would redirect existing resources, use federal grants, and increase the state general fund appropriation to support 3 FTE staff at the Department who will provide technical support to the call centers and outreach sites and to increase the Board on Aging resources to address the substantial increase in contacts that will result with Medicare Part D implementation.

⇒ Second, current PDP participants will begin receiving pharmacy coverage through Medicare Part D on January 1, 2006. Accordingly, the Department is exploring options of transforming PDP to cover other populations (see below).

⇒ Third, this proposal would align state law with the federal Medicare Modernization Act, including:

- Eliminating MA coverage of prescription medications coverable by Medicare Part D for people who are dually eligible for Medicare Part D, effective 1-1-06.
- Retain MA coverage of prescription medications in classes explicitly excluded from Medicare Part D coverage but covered under MA for dual eligibles. Federal match will continue to be available for these classes of drugs.
- Providing authority for the state to auto-assign and enroll full-benefit dual--eligibles into Medicare Part D drug plans if they fail to enroll within the federally prescribed enrollment periods --if permitted by federal regulation.
- Providing authority to communicate information pertaining to full benefit dual- eligibles and Medicare Savings Program enrollees to the Centers for Medicare and Medicaid Services for purposes of the Medicare Part D low income subsidy.
- Providing authority to manage SSA applications as follows:
  - ⇒ Perform an initial screening for people who submit an SSA application to the Department, to determine potential eligibility for Medicare Savings Programs, as required by federal regulation.
  - ⇒ Forward all SSA applications for the Medicare Part D subsidy to SSA.
  - ⇒ Develop and implement a manual process for people who purposefully submit an SSA application to the Department and request the Department --and not SSA-- to determine eligibility for the Medicare Part D subsidy.
- Completing changes to the Department's computer systems necessary to implement Medicare Part D and staff support for Medicare Part D application processing (1 FTE staff in FY 2006, 7 FTEs in FY 2007, and 6 FTEs thereafter). This proposal includes the redirection of existing PDP administrative resources to this activity.
- Preventing state program enrollees who are eligible for Medicare coverage from substituting state program coverage when Medicare is the primary payer for medical services.

The full extent of the State's role in implementing Medicare Part D will be further clarified upon promulgation of final federal regulations.

In addition, the Department will explore transforming the current state-funded pharmaceutical assistance program (SPAP), PDP, to provide coverage for those who have incomes up to 275% of the federal poverty guidelines, but who have no drug coverage. This group would receive a drug discount, rather than full coverage, through the SPAP. In addition, those who met the eligibility criteria for the state's General Assistance Medical Care (GAMC) program would continue to receive drug coverage equivalent to that which would otherwise be received through GAMC, but their prescription medication coverage would be through the SPAP. This restructuring would permit the Department to collect Medicaid-level rebates from pharmaceutical manufacturers, which would offset the costs of this proposal. The Department expects to put forward a more formal budget proposal related to the transformation of PDP during this legislative session.

Key Measures

- Pharmacy Average Monthly Cost Per Recipient

Please see http://www.departmentresults.state.mn.us/hs/index.html for a current report on the current status of Department measures.

Statutory Change: M.S. 256.955, 256B.04, 256.045

Fiscal Impact ($000s)	FY 2006	FY 2007	FY 2008	FY 2009
General Fund				
Expenditures	($7,938)	($6,141)	($6,577)	($7,170)
Net Fiscal Impact	($7,938)	($6,141)	($6,577)	($7,170)

Recommendation

The Governor recommends more cost-effective purchasing of prescription medications for Minnesota Health Care Program enrollees, including:

- Contracting for specialty pharmaceuticals at lower rates.
- Requiring fee-for-service enrollees with hemophilia to obtain covered blood-factor products through federally qualified 340B hemophilia treatment centers.
- Aligning payment rates for administered drugs with Medicare rates.
- Reducing payment rates for other prescription medications dispensed by pharmacies to average wholesale price (AWP) minus 14%.
- Requiring prior authorizing drugs new to the market.

Background

Minnesota Health Care Programs (MHCP) include Medical Assistance (MA), General Assistance Medical Care (GAMC), MinnesotaCare, and Prescription Drug Program (PDP). In administering these programs, the Department pays for a defined set of health care services and supplies for people who meet the categorical, income, and asset requirements of the programs. The benefit set for these programs includes prescription drug coverage. See http://www.budget.state.mn.us/budget/operating/200607/background2/humanservices.pdf for further information about MHCP.

Health care costs for MHCP continue to increase. Cost increases can be attributed to a number of factors, including growth in the ingredient cost of prescription drugs. The U. S. Department of Health and Human Services Office of the Inspector General (OIG) issued a report in September 2004 titled "Variation in State Medicaid Drug Prices." This report highlighted significant differences between state Medicaid agencies in the reimbursement paid to pharmacies for a sample of prescription drugs. The OIG concluded that Medicaid could have saved approximately $87 million in the 42 states studied if those states had paid at the same rate as the lowest paying state.

The following proposals would constrain the rate of growth of prescription drug costs for Minnesota's publicly funded health care programs while maintaining access to quality health care for enrollees.

Specialty Pharmaceutical Contracts

Current program. Certain prescription drugs are usually shipped by specialty pharmacies to MHCP recipients. These drugs are often injectable drugs that are very expensive. Examples include Enbrel, Avonex and Humira for which MHCP's average payment per claim exceeds $1,150. The cost and special storage requirements of these drugs inhibit many regular pharmacies from stocking them. Medicaid programs in other states have negotiated contracts with limited networks of specialty pharmacies. Under those contracts, specialty pharmacies have accepted reimbursement of approximately average wholesale price (AWP) minus 18 or 19%, rather than the AWP minus 11.5% the Department currently pays.

Proposal. This proposal would authorize the Department to contract with a limited network of pharmacies to provide specialty pharmaceuticals to MHCP enrollees. The proposal would save an estimated $90 per claim for these drugs based on a payment of AWP – 18.5%. These prescriptions will be available via mail order for beneficiaries and therefore a more limited network will not create access problems for MHCP enrollees.

Hemophilia Blood-Factor Products from 340B Providers

Current program. People with hemophilia frequently require infusions of blood-factor products to control bleeding episodes. Most hemophiliacs have their blood-factor products shipped to them –either by a 340B provider or a regular provider.

Federal law provides that Medicaid programs may purchase blood-factor products at relatively lower payment rates through a provider qualified under Section 340B of the Public Health Act.

In Minnesota, Fairview-University currently has a 340B-qualified hemophilia treatment center, and Mayo Clinic has a center that may become qualified.

Proposal. This proposal would authorize the department to limit purchase of blood factor products to 340B providers effective 10-1-05. Even with the loss of manufacturer rebates, the department would reduce the MHCP costs for purchasing these products.

Enrollees who are currently diagnosed with hemophilia would be notified well in advance to avoid disruptions of their supply of blood factor products. These products will be available via mail order for beneficiaries and therefore a more limited provider network will not create access problems for MHCP enrollees.

Payment Rates for Administered Drugs
Current program. Certain covered drugs are administered in outpatient facilities and billed to the Department. Our current payment rate for these drugs is AWP minus 5%. This rate was specified in statute several years ago to align with the rate Medicare paid for administered drugs at the time. (Prior to that, the department paid the full AWP.)

Under the Medicare Modernization Act, Congress adopted a change to Medicare reimbursement for administered drugs that was phased in over time. The current Medicare rate is based on average sales price (ASP). These new rates more closely approximate the prices at which providers purchase drugs.

Proposal. This proposal would align MCHP payment rates for administered drugs with the contemporary Medicare rate effective 7-1-05.

Pharmacy Payment Rates to AWP minus 14%
Current program. In 2003, the Legislature reduced fee-for-service pharmacy payment rates for MHCP to AWP minus 11.5%.

Federal and state law and regulations direct the department to pay pharmacy providers at the actual acquisition cost of a drug plus a reasonable dispensing fee. Where *average* wholesale price represents the *actual* wholesale price, AWP minus 14% is a better estimate of actual acquisition cost than AWP minus 11.5%. The U.S. Department of Health and Human Services Office of Inspector General issued a report in 2002 that suggested pharmacies purchase brand name prescription medications at an average of 17.2% less than AWP.

Proposal. This proposal would reduce MHCP payment rates from AWP minus 11.5% to AWP minus 14% effective 7-1-05. This proposal provides more accurate payments to providers plus a reasonable dispensing fee while protecting access for beneficiaries.

Prior Authorization of New Drugs
Current program. Newly approved drugs usually cost much more than drugs that are already on the market. Frequently, the new drugs offer few, if any, advantages over the existing drugs. Currently, if the department wants to subject a new drug to prior authorization, the drug formulary committee (DFC) must review the drug at a public meeting. After the meeting, the department has to allow for a 15-day comment period and a 15-day notification period. Since the DFC normally meets only four times per year, there is typically a significant delay in establishing prior authorization criteria for new drugs. During that period of delay, thousands of enrollees can start taking the new drug. That results in increased costs for more expensive drugs that may offer little additional benefit. Past examples of such drugs include Nexium, and even the anti-inflammatory drugs Vioxx, Celebrex and Bextra.

If the department had this authority when Vioxx and Celebrex were introduced to the market, the MHCP would have saved over $1.5 million annually just on those two drugs.

A number of other state Medicaid programs subject new drugs to prior authorization for up to 6 months.

Proposal. This proposal would authorize the department to subject drugs newly approved by the Food and Drug Administration (FDA) to prior authorization for up to 180 days without having to go through the regular DFC review process, effective 7-1-05. The DFC would establish general criteria for handling prior authorization requests for newly approved drugs. This proposal would provide the department the flexibility to allow unrestricted coverage of a new drug that is clearly superior to existing drugs or of drugs for which the manufacturer is willing to pay supplemental rebates.

Relationship to Base Budget

This represents a 2.2 percent reduction to the 2006-07 forecast for fee-for-service pharmacy spending.

Key Measures

Pharmacy average monthly cost per recipient.

Please see http://www.departmentresults.state.mn.us/hs/index.html for a current report on the status of this measure.

Statutory Change: M.S. 256B.0625, subd. 13c, subd. 13e, and subd. 13f.

Change Item: 5% Reduction To Hospital Rates

Fiscal Impact ($000s)	FY 2006	FY 2007	FY 2008	FY 2009
General Fund Expenditures	($16,069)	($35,978)	($41,108)	($44,926)
Health Care Access Fund Expenditures	(1,312)	(2,430)	(2,190)	(2,463)
Net Fiscal Impact	($17,381)	($38,408)	($43,298)	($47,389)

Recommendation

The Governor recommends a 5% reduction in fee-for-service hospital payment rates and associated reductions in managed care for Minnesota Health Care Programs. This proposal would reduce MA, GAMC, and MinnesotaCare fee-for-service payment rates for inpatient and outpatient hospital services by 5% effective 7-1-05. Managed care rates would be reduced by 2.01% for MA, 2.2% for GAMC and 1.83% for MinnesotaCare effective 1-1-06 to reflect the difference in the hospital component of capitation payments. The proposal excludes mental health diagnostic-related groupings (DRGs) and Indian Health Services.

Background

Current program. Minnesota Health Care Programs (MHCP) include Medical Assistance (MA), General Assistance Medical Care (GAMC), MinnesotaCare, and Prescription Drug Program (PDP). In administering these programs, the Department pays for a defined set of health care services and supplies for people who meet the categorical, income, and asset requirements of the programs. The benefit set for MA, GAMC, and MinnesotaCare includes coverage of inpatient and outpatient hospital services. See http://www.budget.state.mn.us/budget/operating/200607/background2/humanservices.pdf for further information about MHCP.

Health care costs for MHCP continue to increase. Cost increases can be attributed to a number of factors, including growth in expenditures for hospital services.

Relationship to Base Budget

This represents a 1.3 percent reduction to the department's fiscal year 2006-07 forecast for basic health care grants (MA, GAMC, and MnCare).

Key Measures

- MHCP cost increases.
- Inpatient average monthly cost per recipient.

Please see http://www.departmentresults.state.mn.us/hs/index.html for a current report on the status of these measures.

Statutory Change: M.S. 256.969, 256B.32, 256B.69, 256B.75, and 256L.12.

Fiscal Impact ($000s)	FY 2006	FY 2007	FY 2008	FY 2009
General Fund				
Expenditures	$51,377	$43,840	$48,461	$52,299
Health Care Access Fund				
Expenditures	(77,923)	(97,331)	(92,819)	(103,017)
Revenues	174	0	0	0
Net Fiscal Impact	($26,720)	($53,491)	($44,358)	($50,718)

Recommendation

The Governor recommends the following changes to Minnesota Health Care Program eligibility effective 10 –1 - 05:

⇒ Reduce MinnesotaCare eligibility for adult parents and caretakers to those with gross income no greater than 190% of the federal poverty guidelines (FPG). Eligibility for pregnant women will be maintained at current levels.

⇒ Discontinue MinnesotaCare eligibility for adults without children.

⇒ Restore spend-down in General Assistance Medical Care (GAMC) and discontinue GAMC-Hospital Only (GHO) coverage. Restoring income spend-down eligibility in GAMC will provide a full benefit safety net for some adults without children who will lose MinnesotaCare or GHO.

Background

Minnesota Health Care Programs (MHCP) include Medical Assistance (MA), GAMC, MinnesotaCare, and Prescription Drug Program (PDP). In administering these programs, the Department pays for a defined set of health care services and supplies for people who meet the categorical, income, and asset requirements of the programs. Federal Medicaid and State Children's Health Insurance Program (SCHIP) funding matches state expenditures in MA and for families with children enrolled in MinnesotaCare. See http://www.budget.state.mn.us/budget/operating/200607/background2/humanservices.pdf for further information about MHCP.

MinnesotaCare currently covers pregnant women and parents/caretakers of children with gross income no greater than 275% FPG and adults without children with gross income no greater than 175% FPG. There is no asset test for pregnant women. The asset test for parents/caretakers and adults without children is $10,000 for a single individual and $20,000 for a household of two or more.

GAMC covers adults without children with gross income to 75% FPG and GAMC-Hospital Only (GHO) covers adults without children who are hospitalized and have gross income from 75% to 175% FPG. GAMC enrollees have a $1,000 asset limit. GHO enrollees have a $10,000 asset limit for individuals and a $20,000 asset limit for couples. The GAMC benefit set is more comprehensive than MinnesotaCare or GHO.

Under this proposal, adults without children who are currently enrolled in MinnesotaCare or GHO would qualify for GAMC if:

- Their gross income does not exceed 75% FPG and their assets do not exceed $1,000.
- Their gross income exceeds 75% FPG, their assets do not exceed $1,000, and they incur medical expenses equal to the difference between their income and 75% FPG. Restoring income spenddown eligibility in GAMC will provide a full benefit safety-net for some adults without children who will lose MinnesotaCare or GHO.

The policy and fiscal effects of this proposal interact with proposals related to health care program management and hospital payment rates.

Please see http://www.departmentresults.state.mn.us/hs/index.html for a current report on the status of this measure.

Statutory Change: MS §256D.03, subd. 3 and Chapter 256L.

Fiscal Impact ($000s)	FY 2006	FY 2007	FY 2008	FY 2009
General Fund				
Expenditures	$2,101	($350)	($1,784)	($3,229)
Revenues	1,552	1,657	1,974	2,029
Health Care Access Fund				
Expenditures	2,946	2,044	3,940	3,971
Revenues	1,173	840	1,598	1,615
Net Fiscal Impact	$2,322	($803)	($1,416)	($2,902)

Recommendation

The Governor recommends that publicly funded health care programs be better managed by:

- Better addressing fraud and abuse;
- Complying with federal program integrity requirements;
- Recovering uncompensated transfers of income and assets;
- Recovering from estates assets held in irrevocable trusts or annuities;
- Implementing intensive medical care management;
- Improving cost-effectiveness of coverage;
- Improving health care enrollment process; and
- Increasing use of web-payment method.

Background

Minnesota Health Care Programs (MHCP) include Medical Assistance (MA), General Assistance Medical Care (GAMC), MinnesotaCare, and Prescription Drug Program (PDP). In administering these programs, the Department pays for a defined set of health care services and supplies for people who apply and meet the categorical, income, and asset requirements of the programs. Federal Medicaid and State Children's Health Insurance Program (SCHIP) funding matches state expenditures in MA and for families with children enrolled in MinnesotaCare. See http://www.budget.state.mn.us/budget/operating/200607/background2/humanservices.pdf for further information about these programs.

Better address fraud and abuse. Recent audits conducted by the Office of the Legislative Auditor (OLA) found deficiencies in the Department's health care program integrity operations and made recommendations to substantially improve the Department's capacity, communication and coordination of integrity functions. In August 2003 the OLA reported that the Department:

- Has not comprehensively estimated the amount or nature of improper payments.
- Does not have data-mining software, an important tool to detect potential improper payment issues.
- Needs to improve the oversight of managed care organization payment control activities.
- Does not have a full range of legal remedies for ensuring the integrity of the MA program.
- Has the same number of provider investigators it had in 1994, despite the dramatic increases in claim volume, claim types and provider types.

The Department has limited investigative staff to identify and respond to all varieties of provider fraud and abuse. This limits capacity to measure the scope of abusive practices among specific MA provider types. The Department is working with an outdated reporting system, and has no specific analytic tools to identify new patterns of abusive practices.

This proposal would increase the resources for these program integrity activities to**:**

- Expand investigations of provider fraud and abuse by increasing staff levels by 3 full-time equivalent (FTE) staff.
- Purchase and utilize tools not previously available to identify and respond to difficult-to-identify abusive and fraudulent billing activities.
- Expand legal remedies by coordinating identification and prosecution of abusive and fraudulent provider activities with local and federal governmental agencies.

These activities are projected to achieve savings for the general fund that exceed the level of investment over the long term.

Comply with federal program integrity requirements. Existing and new federal mandates require an increasing number and scope of recipient-eligibility audits for cases for which the state receives federal match

- *Federal PERM mandate.* In 2002, Congress passed the *Improper Payments Information Act (HR 4878),* requiring federal agencies to report annually on the scope of overpayments and underpayments in their programs. In response, the Centers for Medicare and Medicaid Services (CMS) published draft regulations requiring all states to audit their Medicaid programs annually. This new mandate, known as payment error rate measurement (PERM) will require that the Department implement additional quality control operations beginning in the next biennium to address payment accuracy, recipient eligibility, and the medical necessity of the services purchased. These responsibilities will *not* replace existing federal requirements for Medicaid-eligibility quality control (MEQC).

  Currently, the Department is administering a PERM pilot project funded by a one-year grant from CMS. If the federal PERM regulation is promulgated consistent with the proposed regulation, the Department will need several additional staff. The Department projects that a review of medical payments and recipient eligibility will need to be conducted for a sample of 1,000 or more claims annually.

  This proposal would fund 10 FTE staff who are experts in health care payments, eligibility and quality-control procedures to conduct this labor-intensive activity. Three FTEs would be assigned to medical necessity reviews and 7 FTEs would be assigned to eligibility reviews.

- *Federal MEQC mandate*. In 1997, Minnesota received a waiver from federal MEQC regulations which specify traditional methods and procedures for verifying the eligibility of a sample of people enrolled in Medicaid. In its place, Minnesota and other states have participated in the "Pilot Project for Reforming Quality Control". This CMS-sponsored alternative to the traditional procedures allowed states to design and implement their own quality control or evaluation projects to accomplish the eligibility-verification goals of MEQC. This waiver, and our status as a pilot project, is expected to end on June 30, 2005. At that time, Minnesota will be required by federal regulations to resume traditional MEQC procedures. It is anticipated that we will be required to conduct recipient-eligibility reviews on a sample of at least 1,000 cases annually. The procedure for these reviews will be identical to those conducted for PERM; however, because the two audits are based on different sampling universes and must be performed at the same time, separate staff are required to complete both audits.

  This proposal would fund 7 FTE trained staff to conduct MEQC.

- *MinnesotaCare eligibility audits.* In their January 2003 report, the OLA cited the Department's statutory responsibility to conduct random audits focused on recipient eligibility for MinnesotaCare. In accordance with the OLA's recommendation to increase the frequency of those audits, DHS' Program Assessment and Integrity Division conducted a two-phased study in 2003-04. The audit focused first on the extent to which MinnesotaCare enrollees had access to employer-based or private health insurance, and secondly on income and asset verification for new enrollees. Audits of this type should be conducted routinely to comply with Minn. Stat. §256L.05.

  This proposal would fund 3 FTE staff to conduct MinnesotaCare eligibility audits.

- *MinnesotaCare fraud prevention and control.* In addition to their January 2003 findings concerning random eligibility audits, the OLA recommended that the Department regularly monitor, identify, and intervene with applicant fraud and abuse in MinnesotaCare. Clearly, MinnesotaCare program integrity depends upon procedures that limit participation to only those individuals who meet eligibility requirements. The Department proposes to establish procedures to identify and disenroll people who fraudulently enroll in MinnesotaCare.

The Department has reassigned 1 FTE staff to pursue reports of fraud and abuse by MinnesotaCare enrollees. The preliminary outcome of this new activity has resulted in referrals, monetary recoveries, and voluntary agreements from former program participants who failed to report changes in circumstances or ownership of properties that would have resulted in ineligibility for MinnesotaCare.

This proposal would expand the department's current activities in recipient fraud prevention and control initiatives in the MinnesotaCare Program. In addition to the 1 existing FTE, the proposal would fund 2 FTE investigators who would be trained on fraud and abuse procedures, including detection, reporting and investigation, and 1 FTE for appeals. The fraud prevention and control unit would recommend corrective actions for implementation. The project would be analyzed to determine the cost and benefit of continuing or expanding these activities.

Recover uncompensated transfers of income and assets. Increasingly, MA recipients are strategically making and reporting transfers for less than fair market value in the last 10 days of a month, making it impossible for a financial worker to provide timely advance notice of a penalty period for the following month. This proposal would allow a cause of action to be brought by the county or the Department against the person who received the assets or income for less than adequate compensation when the transfer was reported after the date timely advance notice could be provided to the recipient and the recipient received MA coverage. Deterring people from engaging in these tactics would result in greater enrollee contributions towards the cost of long term care.

Effective for transfers occurring on or after July 1, 2005, this proposal would increase authority to bring legal action against those who received assets or income transferred to them for less than adequate compensation by a recipient who receives MA services because of the divestment of the assets or income.

People with greater means will be required to pay their cost of care. This will result in publicly funded health care cost containment through an increased ability of the agency to recover after assets have been transferred for less than adequate compensation.

Recover from estates assets held in irrevocable trusts or annuities. Federal law requires the State to recover MA payments from the estates of deceased recipients and state law establishing this policy for Minnesota's MA program also applies the policy to the Alternative Care (AC) program. Federal law gives states the option to include assets which are not part of the probate estate in a recipient's estate for purposes of recovering MA. Property held in life estate or joint tenancy was added to the definition of an estate for the purposes of recovery in July 2003.

Recent anecdotal information indicates recipients are putting their life estates in real property into trusts to avoid liens and estate claims for recovery of MA and AC expenses. Also, recipients and community spouses are using sole benefit trusts and annuities as will substitutes to shelter their assets from recovery.

This proposal would allow recovery from all trusts (except supplemental needs trusts, special needs trusts and trusts funded by third persons with their own funds) and annuities in which the recipient or their surviving spouse has an interest when they die, by expanding the definition of "estate" to permit MA and AC recoveries from recipients' interests in trusts and annuities at the time they die. This proposal is intended to be as broad as possible to allow recovery of MA and AC from annuities and trusts used to protect assets and to avoid probate, which may be an element of financial planning.

This proposal would fund 1 FTE staff to implement the provisions. These costs are projected to be offset by an increase in recoveries.

Implement intensive medical care management. Legislation passed in 2003 required the Department to study its health care programs and recommend cost-savings strategies. This proposal is based on that study's findings.

There is a growing recognition that within the population of high-cost recipients, there is a sub-population that comprises a distinct highest-risk segment. These highest risk recipients are often 1 to 3% or less of the total Medicaid population, but can generate 25% of all health costs. In FY2002, 3,631 distinct fee-for-service MA

recipients utilized greater than $100,000 each in health care services. Typically, recipients in this sub-population suffer from more than one chronic condition.

These highest risk recipients are not generally identified through traditional high-cost case management, county case management, or disease management programs because they are often disconnected from the health care system, isolated from the community, and have complex co-morbidities and confounding psychosocial issues.

Near-term hospitalizations can be avoided by providing the proper clinical care management services to these recipients. Attention to the interaction between a recipient's medical needs and their ability to access timely care for their needs has been proven to reengage recipients, resulting in behavioral changes that can reverse the downward slope in health status.

A predictive modeling and intensive medical care management program works as follows:

- A contracted vendor analyzes claim data, including health and pharmacy claims, to identify the recipients they deem to be at high risk of hospitalization within 12 months.
- The vendor ranks the recipients based on the level of risk, and then targets only those at highest risk for intervention.
- Intervention consists of intensive telephonic and in-person outreach and support by highly trained and skilled clinical staff. While not all participants have telephones, when they are accessed by telephone or in person, there is typically a high voluntary engagement rate. The outreach focuses on both medical self-management issues and on personal issues such as isolation, depression, or substance abuse that may directly impact the recipient's ability to manage their chronic medical conditions. The clinical care staff would coordinate with county case managers as necessary to meet the client's needs.

While the cost of this intervention can be considerable, savings and improved health outcomes can be achieved. An independent assessment by Milliman and Robertson of predictive modeling, coupled with intensive clinical care management targeted at the highest risk subpopulation, has documented a return on investment of 3 to 1 in a large *commercial* health plan. Based on the unique nature of the MA population, and on discussions with Minnesota health plan medical directors and local and national vendors that provide this type of intervention, the Department estimates that the state would experience a return on investment ratio of 1.5 to 1.

This proposal would provide intensive clinical medical care management for the 500 fee-for-service MA recipients with complex chronic medical needs. The clients identified for this service would participate on a voluntary basis.

The predictive modeling software used for selection of the subset of participants is proprietary and subject to change as health care practice changes. The Department does not have the internal resources to create or maintain this software. The Department also lacks the clinical staff and the care management protocols necessary to implement this program within the Department. Therefore, the department would use a competitive bidding process to procure a contracted vendor for this project.

Improve cost-effectiveness of coverage. Medical researchers are continuously compiling evidence on the efficacy of various medical procedures and technology, from widely-used, conventional methods such as spinal fusion to alleviate low back pain, to emerging technologies such as that used in the newest methods of diagnostic imaging. This type of information is currently used by commercial health care plans as a form of "industry standard" to make informed decisions regarding which procedures to cover and under what circumstances to cover them in order to maximize the effectiveness of coverage and expenditures.

Although Minn. Stat. §256B.04, subd.1a, establishes DHS' authority to make coverage decisions for MHCP recipients, limited capacity for that function exists within the Department. The Department needs to enhance clinical expertise needed to maximize use of current evidence in making coverage decisions. Improving the Department's capacity to do so would improve the ability to determine the best value for the state and the best care for the recipient.

Based on the findings of the Department's study of its health care programs conducted under the Omnibus Health and Human Services Budget Bill, Chapter 14, First Special session 2003, Article 13C, Subd. 2, sec. 7, this

proposal would subject current MHCP coverage to evidence-based review to determine whether current medical research would suggest significant opportunities for reducing costs and obtaining better value for expenditures. This proposal would put the Department in a better position to assess emerging procedures and technology introduced by medical providers in a more timely manner to avoid unnecessary future costs.

To enable DHS to make better, more clinically-informed decisions, this proposal has the following components:

- *Medical director.* Fund 2 FTE staff for a medical director and support staff. This would assist the Department in making MCHP coverage decisions based on science and medical expertise and improving health outcomes.

- *Medical policy advisory council.* Establish a medical policy advisory council that would include independent physicians and health plan medical directors and would serve as a resource to the medical director. The council would develop medically sound, physician-determined policy recommendations for the Department to reduce inappropriate use of medical services and improve health outcomes, including recommendations concerning whether particular service alternatives within those benefit coverage parameters are medically effective and appropriate and under what circumstances they should be covered. Recommendations would be based on review of new and current covered benefits and medical research provided by a Medicaid evidence-based practice center.

- *Multi-state Medicaid evidence-based practice center.* Establish, as part of a multi-state consortium, a Medicaid evidence-based practice center that would provide the medical director and medical policy council information and recommendations based on contemporary medical literature. The center would focus on topics selected by member Medicaid agencies. This would assure that the research was focused on medical issues specific to the Medicaid population.

  The evidence-based practice center would be similar in function, operation, and funding to the effort in which Minnesota currently participates with 10 other states for drug coverage decision-making. In that effort, the eleven states have formed a consortium that funds research the states direct.

  The Department initiated a dialog with the nation's state Medicaid directors, and 47 states have expressed interest in the concept. Based on this interest, the National Association of State Health Policy (NASHP) agreed to seek start-up funding from national organizations such as the Commonwealth Fund. NASHP's efforts at fundraising have been going well. As a result, NASHP, Minnesota and the other interested states are planning an initial organizational meeting in January 2005. Based on the experience of the aforementioned drug research center, the new policy center should be operational by July 2005.

  Minnesota's projected annual cost is $50,000 for the center. The actual amount will vary dependent upon the number of states participating.

Improve health care enrollment process. Most publicly funded basic health care programs are administered by local county agencies. MinnesotaCare is administered by the Department (MinnesotaCare Operations) and by counties that have chosen to do so. Public administration of these programs in 87 counties is inefficient and a barrier to improving program integrity and customer service.

The largest portion of the Department's budget is expended on health care programs, and in many cases, health care eligibility administration is a relatively low priority for counties. Counties are challenged to manage the burden of the current health care program caseload, resulting in poor customer services and inaccurate eligibility determinations. Program changes such as implementation of Medicare Part D and shifting of MinnesotaCare enrollees to MA, will increase county caseloads over the next 24 months.

Predominately central administration of MinnesotaCare has served a substantial portion of MinnesotaCare enrollees well. For some, however, personal assistance offered in their local communities would benefit applicants who become frustrated with the paperwork involved in the application or renewal process. The ideal enrollment system would allow uninsured Minnesotans to choose between remote access via the internet or telephone or personal assistance at a local agency.

HealthMatch, an automated web-based eligibility system, is projected to be fully implemented state-wide effective July 1, 2006. HealthMatch will incorporate MA, GAMC and MinnesotaCare eligibility and enrollment into one system and essentially one virtual program with different benefit sets and cost-sharing. This will require that all eligibility workers be versed in all health care programs.

Although HealthMatch will improve speed and accuracy and produce consistent eligibility determinations, it will not address issues related to managing paper applications and documents or deficiencies in expedient access to information and enrollment forms.

Until HealthMatch is implemented, the Department's MinnesotaCare Operations will continue to process eligibility determinations with minimal systems support. The MinnesotaCare Program has grown 27% since 2001. MinnesotaCare Operations manages 94% of the state's 70,037 cases and continues to receive an average of 5,000 new applications and 67,000 phone calls per month. In addition to an overall increase in cases, the workload has essentially doubled for operations staff with implementation of 6 month renewals. Authority to carry forward unspent administrative funding from FYs 2002-03 has made it possible for MinnesotaCare Operations to manage this increased workload. That additional funding will be expended before HealthMatch implementation is completed and MinnesotaCare Operations is able to process cases with fewer staff.

This proposal would use base MinnesotaCare Operations funding plus an increased appropriation to improve the health care eligibility and enrollment process. The improved business process will expedite enrollment of low-income uninsured Minnesotans, improve the efficiency and integrity of Minnesota's publicly funded health care programs, and reduce local government administrative costs.

- *Transition to HealthMatch and new business process.* Continue the FY 2005 MinnesotaCare Operations staff levels until HealthMatch is fully implemented in order to reduce delays in processing due to implementation of 6-month renewals, convert cases to HealthMatch, and transition to providing a platform for improved business processes described below.*

- *Implement waiver.* Upon implementation of HealthMatch, implement the federally authorized project under Minn. Stat. §256B.78 to demonstrate whether improved access to pre-pregnancy family planning services reduces MA and Minnesota Family Investment Program (MFIP) costs. Implementation includes eligibility case maintenance, training, evaluation, outreach and other related costs.

- *Customer service center.* Beginning in FY 2007, provide statewide direct access to health care program information, applications and health plan enrollment by telephone and internet to provide fast and consistent customer service and reduce administrative burden for local agencies.

- *Centralized electronic document management and data entry system.* In FYs 2007-08 expand MinnesotaCare Operations electronic document management system to facilitate statewide document management for publicly funded health care programs. The statewide system would simplify the submission of paper documents, provide a fast and secure transfer of case records, eliminate duplication, provide data for performance management, and apply consistent processes for enrollment in prepaid health plans. Centralized document management would also offer opportunities for local governments to combine resources for data entry or shared caseload distribution.

- *Central administration of on-line applications and other processes.* In FY 2007, begin to centrally administer all applications and renewals that are submitted on-line, basic-change data entry (e.g., change of address), and health plan enrollment. This approach would encourage use of technology to reduce administrative activities in general and minimize the stigma of public program enrollment for people who chose to apply on-line.

  This would also alleviate local government of administering cases that can be handled more efficiently in a centralized manner to allow counties to better assist people who require personal assistance to access eligibility and services and people who submit paper applications.

Increase use of web-payment method. The Department implemented a web-payment system in July 2003 to improve customer service and the Department's ability to manage fee collection without additional administrative resources.

Currently, 5,500 MinnesotaCare enrollees use the system to pay their premiums by credit card. Recently, the system was expanded to allow licensing, parental fee, MA-for employed people with disabilities, and other customers to use the system to make premium or fee payments.

The processing fees assessed by credit card companies average $1.25 per transaction (the fee varies by credit-card company and is typically a percentage of the transaction amount). In addition, the Department is assessed a fee of $.51 per transaction for payments processed through EZ Gov. The total processing fee cost is projected to be $127,000 in FY 2005. The Department projects that a greater percentage of payers will use the web-payment system each year. Reduced Department administrative resources no longer make it possible for the agency to absorb these processing fees, especially as usage increases.

The Department continues to be able to handle an increased volume of incoming receipts without increasing receipts-processing staff due to innovations such as this, but web volume must increase by at least 300% over current volume before direct savings or staff reductions are possible (assuming other non-web processing volumes do not increase).

This proposal would support increased use of the DHS web-payment system by funding the credit-card processing fees.*

***Interaction with Restructure Health Care Program Eligibility.** The change item to Restructure Health Care Program Eligibility impacts the proposals listed in this change item because it would reduce the number of people served by the Department. These interactive effects have been taken into account in the fiscal impact identified in the table at the top of the first page of this change item. Therefore, if the proposal to Restructure Health Care Program Eligibility is not adopted, the cost of this change item would increase as follows:

- *MinnesotaCare Eligibility Audits.* Requires a net state expenditure $91,000 greater for FYs 2006-07, including 1 additional FTE staff.
- *Require Fraud prevention and control.* Requires a net state expenditure $282,000 greater for FYs 2006-07, including 3 additional FTE staff (additional investigator, programmer and policy consultant).
- *Improve health care enrollment process.* Requires a net state expenditure $1,160,000 greater for 2006-07 biennium, including 32 additional FTE staff in FY 2006 and 35 additional in FY 2007.
- *Increase use of web-payment method.* Requires a net state expenditure $46,000 greater for FYs 2006-07.

Relationship to Base Budget

This proposal would be a 1.8% increase to the Department's general fund appropriation for office administration and a 7.6% increase to the health care access fund for the same.

Key Measures

- Minnesota health care program cost increases.

Statutory Change: M.S. 256.01, 256B.0595, 256B.0625, 501B.89

Preliminary Proposal

Fiscal Impact ($000s)	FY 2006	FY 2007	FY 2008	FY 2009
General Fund				
Expenditures	($259,823)	($420,338)	($461,013)	($497,896)
Revenues	($96,108)	($190,601)	($121,917)	($137,584)
Health Care Access Fund				
Expenditures	$259,823	$420,338	$461,013	$497,896
Revenues	$93,407	$186,369	$115,498	$129,338
Net Fiscal Impact	$2,701	$4,232	$6,419	$8,246

Recommendation

The Governor recommends that General Assistance Medical Care be funded from the health care access fund (HCAF), rather than the general fund (GF), and that existing basic health care provider surcharges be directed to the health care access fund. MinnesotaCare would continue to be funded from the health care access fund as well.

The Governor also recommends that the Department develop recommendations to simplify publicly funded health care program financing for the 2008-09 biennium.

Background

In 1992 the HCAF was established as a direct-appropriated special revenue fund for the MinnesotaCare Program. Current HCAF resources are derived from the following sources:

- A two percent tax on gross provider revenues
- A one percent tax on gross health maintenance organization (HMO) premiums
- Enrollee premiums
- Interest earned on deposits in the fund
- Federal revenue for certain Department administrative activities
- Federal participation through a Medical Assistance waiver and S-CHIP

The November 2004 forecast projects a HCAF balance of $770 million and a structural balance of $284 million at the end of FY 2009. This level of balance is primarily due to the projection that a large portion of MinnesotaCare enrollees who also qualify for Medical Assistance (MA) or General Assistance Medical Care (GAMC) will move from MinnesotaCare to those programs with planned changes to health care eligibility processes that will be implemented with the Department's new automated health care eligibility system, HealthMatch. With this shift, funding for these enrollees will be derived from the GF, rather than the HCAF.

This proposal would make the following changes to expenses and revenues of the HCAF:

- Finance the GAMC program from the HCAF, rather than the GF, effective October 1, 2005;
- Discontinue HCAF transfers to the GF associated with provider and premium taxes on MA and GAMC revenues beginning in FY 2006;
- Continue year-end-balance transfers from the HCAF to the GF beyond FY 2007, but limit the value of the transfers to approximately $50 million each year, the estimated value of the MA and GAMC provider tax; and
- Direct HMO and hospital MA surcharge revenues to the HCAF beginning in FY 2007.

The HCAF's ability to fund both GAMC and MinnesotaCare is dependent on the timing and level of the projected shifts between MinnesotaCare and MA and GAMC that are related to new eligibility processes; the level of coverage in the MinnesotaCare Program; renewal of federal waiver authority to obtain federal Medicaid and State-Children's Health Insurance Program (S-CHIP) match for MinnesotaCare; and the level of growth in the restructured GAMC and MinnesotaCare programs.

To address these risk factors, this proposal would continue the current law forecast nature of MinnesotaCare during a time of a number of substantive changes to health care programs.

Given the complexity of this proposal and the variety of program and financing changes that will occur in the FY 2006-07 biennium, this proposal would also direct the Department to make recommendations to simplify publicly funded health care program financing for the FY 2008-09 biennium. These financing simplification recommendations should be developed after previously mentioned changes in Minnesota Health Care Programs have occurred and their effects are more fully understood.

There is significant interaction of this proposal with the Governor's recommendation to restructure Minnesota Health Care Program eligibility.

Relationship to Base Budget

This proposal would affect the fund from which the Department's budget is appropriated, not the level of funding.

Statutory Change: Minn. Stat. 295.581

Fiscal Impact ($000s)	FY 2006	FY 2007	FY 2008	FY 2009
General Fund				
Expenditures	($236)	($1,360)	$1,714	($110)
Revenues	0	0	0	0
Net Fiscal Impact	($236)	($1,360)	$1,714	($110)

Recommendation

The Governor recommends that resources that would have automatically increased *some* Medical Assistance (MA) nursing facility (NF) rates in FY 2006 be redirected so that effective October 1, 2005, *all* MA NFs would receive a two percent increase over their rates in effect on June 30, 2005. This rate increase would be flexible funding to better enable the nursing facilities to transition to a new reimbursement system that encourages and financially rewards higher quality and greater efficiency.

Background

Current program. Minnesota's Medicaid Program, known as Medical Assistance (MA) pays for coverage of NF services for people who meet the categorical, income, and asset requirements of the program. See http://www.budget.state.mn.us/budget/operating/200607/background2/humanservices.pdf for further information about MA and NF coverage.

In 2001 the Legislature instructed the Department to develop recommendations for a new reimbursement system for NFs. The Department contracted with the University of Minnesota to assist in developing a new reimbursement system that factors both cost and quality into its rate setting.

In 2004 the Department presented the report, "Value-Based Reimbursement: A Proposal for a New Nursing Facility Reimbursement System," to the Legislature and sought enactment of the new reimbursement system. As an interim step, the Legislature directed the Department to establish a new NF reimbursement system effective 10-1-06. Over the past year, the Department has worked with a committee of stakeholders to refine the proposed system. The new system will be similar to that proposed in the 2004 report.

Proposal. Effective October 1, 2005, all MA NFs would receive a two percent increase over their rates in effect on June 30, 2005. This rate increase will be flexible funding to better enable the nursing facilities to transition to the new reimbursement system. This proposal would phase in the new NF payment system over four years, beginning 10-1-06. To transition to the new reimbursement system, effective 7-1-05, the automatic MA rate adjustments for operating and property costs for NFs under contract through the alternative payment system (APS) will be incorporated into the new reimbursement system. For the first two biennia, (FY 2006-07 and FY 2008-09) most of these funds will be redirected for NFs to transition to the new reimbursement system and to increase staffing levels.

Characteristics of the new system. The new NF reimbursement system will consider quality of services provided when establishing payment rates. It will provide direct incentives to encourage both quality and efficiency by establishing "target prices" and allowing variations from those prices depending on a NFs level of quality and its own costs. A facility's costs will be compared with a target price. Facilities with costs above the target will receive a large portion of the differences if they are high quality, and none if they are low quality. Facilities with costs below the target will also keep a portion of the difference if they are high quality, but very little if they are low quality.

The system will provide facility-specific, prospective rates. The rates will be determined annually, using statistical and cost information filed by each NF.

The proposed system will:

- Recognize legitimate costs;
- Encourage efficiency and quality;
- Reduce rate disparities; and

- Give providers financial incentives for delivering quality services and achieving good outcomes for residents.

Phase-in and funding to ease transition to new system. The new reimbursement system is a major change for providers and could result in some providers receiving large rate increases or decreases. To ease the transition, this proposal includes a phase-in of the new system by blending rates under the old system with those determined under the new system. The blending would involve an increase in the portion of the actual payment rate coming from the new system over a period of four years.

In addition, automatic rate increases for operating costs in FYs 06-07 will be redirected to:

⇒ Initially hold NFs harmless from significant decreases in their rates as they transition to the new reimbursement system;

⇒ Assist NFs to improve their overall quality before the new reimbursement system is implemented. This will be provided through a flexible funding allocation which facilities can spend to improve quality and better position themselves to succeed in the new reimbursement system. For example, facilities may improve employee staffing levels, rate of pay, or other business needs;

⇒ Target higher payments to NFs that improve quality or are of high quality. High quality NFs will be rewarded by having the option to transition to the new reimbursement system sooner; and

⇒ Increase direct care-staffing levels effective 7-1-07.

To further ease the transition to the new reimbursement system and to increase staffing levels in NFs, automatic rate increases for operating costs in FY 2008-09 will be redirected to fund improvements in staffing levels.

This approach will better prepare NFs to succeed under the new reimbursement system and supports the development of a smaller, more financially healthy NF industry. Nursing facilities that are of high quality or that improve quality will prosper under the new system. Those of low quality that do not take steps to improve quality may eventually close.

Key Measures

- Proportion of elders receiving publicly funded services in institutional versus community settings.
- Proportion of public long-term care dollars expended in institutional versus community settings.
- Proportion of nursing home days paid by funding source.

Please see http://www.departmentresults.state.mn.us/hs/index.html for a current report on the status of these measures.

Statutory Change: M.S. 256B.41 to 256B.47

Change Item: Manage Caseload Growth in Home and Community Based Waivers

Fiscal Impact ($000s)	FY 2006	FY 2007	FY 2008	FY 2009
General Fund				
Expenditures	($13,372)	($38,074)	($30,983)	($11,394)
Net Fiscal Impact	($13,372)	($38,074)	($30,983)	($11,394)

Recommendation

The Governor recommends a continuation of caseload growth management in three of the state's home and community-based waiver programs during FYs 2006 and 2007: Community Alternatives for Disabled Individuals (CADI) Waiver, Traumatic Brain Injury (TBI) Waiver, and Mental Retardation and Related Conditions (MR/RC) Waiver.

Background

Minnesota's Medicaid Program, known as Medical Assistance (MA), pays for coverage of home and community-based services as an alternative to institutional care for people who would meet categorical, income, and asset requirements if they were institutionalized. State expenditures for MA are matched with federal Medicaid funding. See http://www.budget.state.mn.us/budget/operating/200607/background2/humanservices.pdf for further information about MA and home and community-based waivers.

The CADI Waiver covers non-institutional services for approximately 12,000 people with disabilities under the age of 65 who meet requirements for a nursing facility (NF) level of care. The level of care need is determined through a Long-Term Care Consultation Services Assessment. The person must demonstrate the need for assistance because of one or more of the following:

- Need for restorative, rehabilitative or other special treatment
- Unstable health
- Need for complex care management
- Functional limitation
- Existence of complicating conditions
- Cognitive or behavioral condition
- Frailty or vulnerability

The TBI Waiver serves as an alternative to either placement in a nursing facility (NF) or the neurobehavioral hospital entitlement in the state's Medicaid plan. People who are eligible for the TBI Waiver have significant cognitive impairments and/or severe behavioral challenges. In addition to being at risk of institutionalization in an NF or neurobehavioral hospital, many TBI waiver recipients also face the possibility of being placed in a state-operated regional treatment center.

- The TBI Waiver currently serves approximately 1,380 individuals.
- About 25% of the TBI waiver recipients require a neurobehavioral hospital level of care.
- The other 75% of the TBI waiver recipients require the level of care provided in a NF.

The MR/RC Waiver serves as an alternative to the intermediate care facility for people with mental retardation (ICF-MR) entitlement in the state's Medicaid plan. The MR/RC Waiver currently serves about 15,550 individuals. The MR/RC waiver caseload is impacted by three mechanisms:

- Conversion: The relocation of a person to the community when an institutional bed closes.
- Turnover: Reuse of existing allocations vacated by waiver recipients.
- Diversion: Addition of new caseload for diverting a person from entering an institution.

Federal law establishes that the ICF-MR service is a Medicaid entitlement. Because of the ongoing reduction in the use of ICF-MR services, MR/RC waiver diversions are used to meet the state's obligation to provide services to people who are newly identified as "in need of services." Turnover within the system is used by either people converting from institutional services or people who are recently identified as in need of services (thus, they also enable the state to meet its entitlement obligations but are not counted as new caseload growth). A caseload

managed in this way still allows for some needed flexibility at the county level, potentially protecting service settings that would become unstable because of loss of clients.

In 2003 state law changed to allow the Department to manage new caseload growth in the CADI and TBI waiver programs. The law also created tools to manage growth in the MR/RC waiver program by not allocating any new diversions during FYs 2004-05. This proposal would essentially maintain current policy.

Effective 7-1-05, this proposal would manage growth in CADI, TBI, and MR/RC waivers for each year of FY 2006-07 biennium:

- CADI Waiver caseload growth would expand by a maximum of 95 per month.
- TBI Waiver caseload growth would expand by a maximum of 150 slots per year.
- MR/RC Waiver new diversion growth would expand by a maximum of 50 allocations to be awarded for emergency purposes.

Key Measures

- Proportion of public long-term care dollars expended in institutional versus community settings.

Please see http://www.departmentresults.state.mn.us/hs/index.html for a current report on the status of this measure.

Statutory Change: Not applicable.

Fiscal Impact ($000s)	FY 2006	FY 2007	FY 2008	FY 2009
General Fund				
Expenditures	$17,731	$19,797	$23,653	$27,822
Revenues	1,773	1,980	2,365	2,782
Net Fiscal Impact	$15,958	$17,817	$21,288	$25,040

Recommendation

The Governor recommends an increased appropriation to address an increase in the number of referrals and commitments to the Minnesota Sex Offender Program (MSOP) and the Minnesota Security Hospital (MSH).

Background

Current Program

Minnesota Statutes, chapter 253B, requires that the Department of Human Services (DHS) State-Operated Services (SOS) provide treatment to individuals who are committed by the court system as mentally ill and dangerous (MI&D); sexually dangerous persons (SDP); or sexual psychopathic personalities (SPP) into the forensic service treatment programs provided at the MSH and the MSOP.

See http://www.budget.state.mn.us/budget/operating/200607/background2/humanservices.pdf for further information about the current programs.

Minnesota Sex Offender Program Demand

Prior to FY 2004, the MSOP population was growing by about 18 persons committed as sexually dangerous persons or sexual psychopathic personalities each year. MSOP experienced a net increase in population of 34 people in FY 2004 and is projected to increase by 63 in FY 2005 (a net total of 97 people over the biennium). The Department currently projects that this rate growth will continue by 25 people through FY 2006, 23 in FY 2007, and then maintain that level of annual growth thereafter.

This growth in utilization has necessitated the staffing of an additional 50 MSOP beds in FY 2004, 55 in FY 2005, 25 in FY 2006, and 25 in FY 2007. The Governor has separately recommended deficiency funding to address the increase in operating costs for FY 2005. This proposal would address the ongoing operating costs for the 105 MSOP beds needing deficiency funding and the 50 beds needing to be added by the end of FY 2007.

Minnesota Security Hospital Admissions

The number of people admitted to MSH who are mentally ill and dangerous has increased and the number of discharges has decreased. Through FY 2003, annual growth in this population was typically 5 per year. In FY 2004 the population grew by 18. While the exact cause of growth is unknown, heightened awareness of public safety issues could be affecting referrals to the MSH. The Department currently projects this trend to continue and estimates net growth of 8 in 2006 and 7 in 2007.

Based on the present rate of growth, the Governor has separately recommended deficiency funding to staff an additional 50 MSH beds beginning in FY 2005. This proposal would address the ongoing operating costs for these 50 MSH beds beginning in FY 2006.

Proposal Details

This proposal would increase the operational funding to provide forensics treatment in a total of 205 additional beds:

- 155 MSOP beds (50 were opened in FY 2004; 55 are opening in FY 2005; 25 will be opened in FY 2006 and 25 will be opened in FY 2007.)
- 50 MSH beds

Finally, this proposal would permit security improvements to the St. Peter campus to continue to assure public safety needs are met. These improvements include an electronic monitoring system for the campus, and check in stations.

Relationship to Base Budget

This proposal would be 5.6% change to the department's base budget for State Operated Services for the FY 2006-07 biennium.

Statutory Change: Not applicable

Fiscal Impact ($000s)	FY 2006	FY 2007	FY 2008	FY 2009
General Fund				
Expenditures	$239	$3,235	$4,758	$6,262
Revenues	34	34	34	34
Net Fiscal Impact	$205	$3,201	$4,724	$6,228

Recommendation

The Governor recommends improving mental health services for people enrolled in Medical Assistance (MA), MinnesotaCare (MNCare), and General Assistance Medical Care (GAMC) by filling some gaps in the mental health system, with a focus on access to care and at-risk children.

Background

Model Benefit Set

Our current mental health system is fragmented, due in part to inadequate coverage of a complete continuum of services by most payers. Problems are associated with lack of access to appropriate and effective care, utilization of funded services that are inappropriate or ineffective, and shifting of costs among public and private payers.

The Minnesota Mental Health Action Group (MMHAG) - a public-private partnership working to design a more client centered mental health delivery system - has defined a model benefit set that it recommends be covered by payers to improve the system of care for people with mental illnesses and children with emotional disturbances. (See http://www.citizensleague.net/mentalhealth/index.html for further information about MMHAG.)

The model benefit set is a continuum of clinical services, as well as supportive services that are sometimes necessary for an effective treatment outcome. The services were selected based on documented and evidence-based mental health best practices.

The benefit set includes services that provide earlier help as well as services that offer alternatives that are just as effective as more costly acute care for some individuals. By offering a full continuum of care, the system would have flexibility to meet consumer needs, which should lead to better outcomes and increased satisfaction. Service provision would be based on medical necessity and in accordance with an individualized treatment plan approved by a physician or licensed practitioner.

Proposal Details

The following changes to publicly funded mental health treatment will fill some gaps in the current benefit set and improve the delivery system in a manner more consistent with proven treatment approaches.

Treatment foster care. MA would cover treatment foster care for children and youth with severe emotional disturbances. The service would combine intensive case management and therapy support in the home of specially trained and supported foster parents. While treatment foster care is provided in several forms in Minnesota, this proposal would establish standards for the service covered as an MA benefit. This proposal would be effective 7-1-06.

Psychiatric case consultation. The acute shortage of psychiatrists within Minnesota means that much of the care for persons with mental illness is handled through primary care physicians. Currently, MA covers consultation provided by any physician to any enrolled professional through interactive video, as long as the patient is present with the professional. For hard-to-access professionals, e-mail, phone or fax without the patient present is a more practical way to provide consultation.

Based on recommendations from a work group that included mental health professionals, primary care physicians, health plans and others, MA, GAMC and MNCare would cover case consultation between a psychiatrist and primary care physician to allow primary care doctors to access valuable, on-demand information necessary to deliver better quality treatment of their patients' mental health disorders. This proposal would be effective 1-1-06.

Interactive video. Interactive video, or telemedicine, is increasingly accepted as an effective means of delivering mental health services, especially in rural areas where specialists are not readily available. Medicare covers mental health services provided to patients using interactive video that meets certain quality standards. This proposal would better align MA, GAMC and MNCare coverage with federal Medicare policy. This proposal would be effective 1-1-06.

Assertive community treatment for youth in transition. Assertive community treatment (ACT) was recently added to the MA benefit set for adults with serious and persistent mental illness. ACT means non-residential adult rehabilitative mental health services provided by a multidisciplinary staff using an evidence-based, total team approach directed to recipients with a serious mental illness who require intensive services. This service approach also shows promise for adolescents with severe emotional disturbance who are making the transition to independent living. This proposal would cover assertive community treatment for 16 and 17-year-old Medical Assistance enrollees who are making a transition to independent living. This proposal would be effective 7-1-06.

Administration. This proposal would provide one full-time-equivalent employee to the Department to implement provider standards training and administer provider enrollment for these new services.

Key Measures

- Percentage of children reunified in less than 12 months from the time of the latest removal from home.
- Percent of persons with serious and persistent mental illness or severe emotional disturbance served in institutional settings.
- Average days in an institutional setting per recipient with mental illness or severe emotional disturbance.
- Percent of persons with serious and persistent mental illness readmitted to a hospital setting within 30 days of discharge.

Please see http://www.departmentresults.state.mn.us/hs/index.html for a current report on the status of these measures.

Statutory Change: M.S. 256B.0622, 256B.0625 and 256L.03.

Change Item: Expand Methamphetamine Treatment Capacity for Women with Children

Fiscal Impact ($000s)	FY 2006	FY 2007	FY 2008	FY 2009
General Fund Expenditures	$300	$300	$300	$300
Net Fiscal Impact	$300	$300	$300	$300

Recommendation

The Governor recommends an increased appropriation to address increased chemical dependency treatment needs of pregnant women and women with children who are or may be abusing methamphetamine, including providing or arranging for supports necessary for the successful completion of treatment.

Background

The Department pays for treatment for chemical dependency or abuse for people who meet categorical and resource guidelines and are assessed to be in need of treatment. State and federal funds for treatment are administered through a consolidated chemical dependency treatment fund and are managed in conjunction with counties and tribes. See http://www.budget.state.mn.us/buget/operating/200607/background2/humanservices.pdf for further information about chemical dependency treatment programs.

Typically, women constitute about one-third of clients in chemical dependency programs, yet account for approximately one-half of those in treatment for methamphetamine abuse in the state. Given this trend, the Department proposes to focus these treatment and technical assistance funds on improving treatment practices for pregnant women and women with children.

There is substantial knowledge in the area of chemical dependency treatment of women, both from national best practices and from providers in the state specializing in the treatment of women. The Department's outcome study indicates that women with multiple or complex problems have better outcomes in programs that specialize in women's services.

Recommendations from the Matrix Institute, a federally-funded treatment program and research center, suggests effective treatment for people addicted to methamphetamine requires 206 hours of outpatient treatment, which is considerably more than other chemical dependency treatments. This increase in the length of treatment will be difficult to achieve without additional funding.

This proposal would increase funding for grants to programs that provide specialized chemical dependency treatment for pregnant women and women with children who are or may be abusing methamphetamine. The programs would provide or coordinate the provision of prenatal care, child care, housing assistance, and other services needed to assure treatment completion.

Relationship to Base Budget

This proposal would be a 0.5% increase to the Department's base general fund for chemical dependency treatment for the 2006-07 biennium.

Key Measures

- Treatment completion rates for the women served by these programs.
- State-wide treatment completion rates for women who are or may be abusing methamphetamine.
- Proportion of positive outcomes for the children of women served by these programs.

Statutory Change: Not applicable.

Agency Purpose

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

Ensuring basic health care for low-income Minnesotans

⇒ Medical Assistance (MA), Minnesota's Medicaid program for low-income seniors, children and parents, and people with disabilities.

⇒ MinnesotaCare for residents who don't have access to affordable private health insurance and don't qualify for other programs.

⇒ General Assistance Medical Care (GAMC), primarily for adults without dependent children.

⇒ Prescription Drug Program to help low-income seniors and people with disabilities pay for prescription drugs.

Helping Minnesotans support their families

DHS works with counties, nonprofits, and Community Action Agencies to help low-income families with children achieve self-sufficiency through programs such as the Minnesota Family Investment Program (MFIP, the state's welfare reform initiative), child support enforcement, child care assistance, Food Support, and refugee cash assistance and employment services.

Aiding children and families in crisis

The department supports families to ensure that children in crisis receive the services they need quickly and close to home so they can lead safe, healthy, and productive lives. DHS guides statewide policy in child protective services, out-of-home care, permanent homes for children, and children's mental health services.

Assisting people with disabilities

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

Direct care services

DHS provides an array of campus and community-based programs serving people with mental illness, developmental disabilities, chemical dependency, and traumatic brain injury and people who pose a risk to society. These programs include services at regional treatment centers in Anoka, Brainerd, Fergus Falls, Moose Lake, St. Peter, and Willmar, Ah-Gwah-Ching the state nursing home in Walker; Community Support Services, which supports people

At A Glance

Health care programs

- Over 652,000 people served in FY 2004
- Medical Assistance (MA)—462,000 people
- MinnesotaCare—148,000 people
- General Assistance Medical Care (GAMC)—35,000 people
- Prescription Drug Program—7,300 people

Economic assistance programs

- Food Support—230,000 people in FY 2003
- Minnesota Family Investment Program (MFIP)—44,800 families
- General Assistance—12,200 people
- Child Support Enforcement—400,000 custodial and noncustodial parents and their children in FY 2003
- Child support collections—$572 million in child support payments FY 2003
- MFIP Child Care Program and Basic Sliding Fee Program—22,700 families and 40,100 children

Child welfare services

- 11,300 children received care from foster families in 2002.
- Almost 7,300 children were cared for by adoptive parents or relatives who receive financial assistance and support for children's special needs in 2003.
- 713 children under state guardianship were adopted in 2002.

Mental health services

- Nearly 25,000 adults with serious and persistent mental illness receive publicly funded mental health services.
- Approximately 20,000 children receive publicly-funded mental health services.

Operations and two-year state budget

- FY 2004-05 $7.0 billion General Fund budget
- FY 2004-05 $17.5 billion all funds budget
- 73% of DHS' General Fund budget is spent on health care and long-term care programs and related services
- 41,000 health care providers
- 45.8 million health encounters and claims processed
- Approximately 97% of DHS' budget goes toward program expenditures
- Approximately 3% of DHS' budget is spent on central office administration

with disabilities in the community and in crisis homes; and Minnesota State Operated Community Services, which provides day training and habilitation and residential services to people with disabilities. State Operated Services (SOS) Forensic Services serve the entire state and include programs for people who pose a risk to society at the Minnesota Security Hospital in St. Peter, the Minnesota Sex Offender Program in Moose Lake and St. Peter, and the Minnesota Extended Treatment Options program in Cambridge.

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

Operations

DHS has a wide variety of customers and business partners, including the state's 87 counties, 41,000 health care providers, and more than 636,000 Minnesotans who are clients or enrollees in DHS programs. DHS provides significant operational infrastructure to Minnesota's human services programs, most of which are provided at the county level.

DHS licenses about 27,000 service providers, including group homes, treatment programs for people with chemical dependency, mental illness, or developmental disabilities, child care providers, and foster care providers. DHS also monitors their compliance with Minnesota laws and rules, investigates reports of possible maltreatment, and completes background studies on individuals who provide direct care.

DHS' operations also support other providers who directly serve Minnesotans. DHS oversees computer system support for: MAXIS, which determines eligibility for economic assistance programs; PRISM, the child support enforcement system; the Medicaid Management Information System (MMIS), which pays medical claims for publicly-funded health care programs; the Social Service Information System (SSIS), an automated child welfare case management system for child protection, children's mental health, and out-of-home placement; and MEC^2, the Minnesota Electronic Child Care system.

Budget

DHS is one of the state's largest agencies, comprising 34% of the state's total spending from all sources. The department's FY 2004-05 budget from all funding sources totals $17.5 billion. Of the total budget for the biennium, $7.0 billion comes from General Fund tax dollars. The remaining $10.5 billion comes from federal revenue and other funds, such as the Health Care Access Fund, Enterprise Fund and Agency Fund. Department staff includes approximately 6,000 full-time equivalent employees.

Contact

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For information on how this agency measures whether it is meeting its statewide goals, please refer to http://www.departmentresults.state.mn.us.

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	3,301,811	3,561,155	3,561,155	3,561,155	7,122,310
Recommended	**3,301,811**	**3,524,869**	**3,804,964**	**3,976,829**	**7,781,793**
Change		(36,286)	243,809	415,674	659,483
% Biennial Change from 2004-05					14%
State Government Spec Revenue					
Current Appropriation	534	534	534	534	1,068
Recommended	**534**	**534**	**534**	**534**	**1,068**
Change		0	0	0	0
% Biennial Change from 2004-05					0%
Health Care Access					
Current Appropriation	273,722	302,272	302,272	302,272	604,544
Recommended	**273,722**	**257,741**	**490,748**	**559,856**	**1,050,604**
Change		(44,531)	188,476	257,584	446,060
% Biennial Change from 2004-05					97.7%
Federal Tanf					
Current Appropriation	270,175	277,515	267,227	267,227	534,454
Recommended	**270,175**	**267,227**	**283,567**	**280,959**	**564,526**
Change		(10,288)	16,340	13,732	30,072
% Biennial Change from 2004-05					5%
Lottery Cash Flow					
Current Appropriation	1,556	1,556	1,556	1,556	3,112
Recommended	**1,556**	**1,556**	**1,456**	**1,456**	**2,912**
Change		0	(100)	(100)	(200)
% Biennial Change from 2004-05					-6.4%
Expenditures by Fund					
Direct Appropriations					
General	3,358,704	3,562,443	3,804,964	3,976,829	7,781,793
State Government Spec Revenue	486	582	534	534	1,068
Health Care Access	312,137	255,386	490,748	559,856	1,050,604
Federal Tanf	254,787	267,291	283,567	280,959	564,526
Lottery Cash Flow	1,527	1,585	1,456	1,456	2,912
Open Appropriations					
Special Revenue	352	667	340	340	680
Statutory Appropriations					
General	37,981	60,724	59,290	59,037	118,327
Health Care Access	0	27,992	26,491	31,386	57,877
Special Revenue	237,521	291,047	146,643	151,106	297,749
Federal	3,751,869	3,734,189	3,899,164	4,072,690	7,971,854
Miscellaneous Agency	606,773	813,237	813,135	813,134	1,626,269
Gift	25	87	75	75	150
Endowment	1	1	1	1	2
Mn State Operated Comm Svcs	67,342	68,258	68,258	68,258	136,516
Mn Neurorehab Hospital Brainer	16,050	18,717	18,717	18,717	37,434
Dhs Chemical Dependency Servs	18,296	18,030	18,030	18,030	36,060
Total	**8,663,851**	**9,120,236**	**9,631,413**	**10,052,408**	**19,683,821**

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Expenditures by Category					
Total Compensation	374,589	382,496	394,596	386,423	781,019
Other Operating Expenses	279,079	363,512	295,182	301,275	596,457
Payments To Individuals	6,531,120	6,837,933	7,404,438	7,822,408	15,226,846
Local Assistance	868,784	900,642	899,079	904,259	1,803,338
Other Financial Transactions	610,279	635,653	634,344	634,512	1,268,856
Transfers	0	0	3,774	3,531	7,305
Total	**8,663,851**	**9,120,236**	**9,631,413**	**10,052,408**	**19,683,821**
Expenditures by Program					
Agency Management	47,031	71,890	66,694	66,082	132,776
Revenue & Pass Through	988,734	1,192,957	1,184,236	1,185,011	2,369,247
Children & Economic Asst Gr	1,104,636	1,127,041	1,112,064	1,130,169	2,242,233
Children & Economic Asst Mgmt	85,431	101,407	100,115	101,143	201,258
Health Care Grants	3,268,873	3,288,979	3,727,833	3,995,803	7,723,636
Health Care Management	71,178	94,724	70,878	70,907	141,785
Continuing Care Grants	2,764,928	2,875,171	3,012,878	3,152,102	6,164,980
Continuing Care Management	32,026	40,356	34,313	34,527	68,840
State Operated Services	301,014	327,711	322,402	316,664	639,066
Total	**8,663,851**	**9,120,236**	**9,631,413**	**10,052,408**	**19,683,821**
Full-Time Equivalents (FTE)	**6,088.6**	**6,113.8**	**6,021.8**	**5,950.9**	

Program Description

The purpose of the Agency Management program is to provide financial, legal, regulatory, management (e.g. personnel, telecommunications, and facility management), and information technology support to all Department of Human Services policy areas and programs.

Budget Activities Included:

⇒ Financial Operations
⇒ Legal and Regulatory Operations
⇒ Management Operations
⇒ Technology Operations

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	39,954	39,530	39,530	39,530	79,060
Subtotal - Forecast Base	39,954	39,530	39,530	39,530	79,060
Governor's Recommendations					
Facilities Consolidation Lease Costs		0	4,537	4,767	9,304
Licensing Requirements		0	1,212	1,036	2,248
Fair Hearing Requirements		0	1,013	842	1,855
MDE Transfer Accounting Solutions		0	802	802	1,604
Total	**39,954**	**39,530**	**47,094**	**46,977**	**94,071**
State Government Spec Revenue					
Current Appropriation	415	415	415	415	830
Subtotal - Forecast Base	415	415	415	415	830
Total	**415**	**415**	**415**	**415**	**830**
Health Care Access					
Current Appropriation	3,673	3,541	3,541	3,541	7,082
Subtotal - Forecast Base	3,673	3,541	3,541	3,541	7,082
Governor's Recommendations					
Facilities Consolidation Lease Costs		0	1,396	1,443	2,839
Restructure MHCP Eligibility		0	436	0	436
Better Manage Health Care Costs		0	192	216	408
Total	**3,673**	**3,541**	**5,565**	**5,200**	**10,765**
Federal Tanf					
Current Appropriation	222	222	222	222	444
Subtotal - Forecast Base	222	222	222	222	444
Total	**222**	**222**	**222**	**222**	**444**
Expenditures by Fund					
Direct Appropriations					
General	31,326	53,568	47,094	46,977	94,071
State Government Spec Revenue	415	415	415	415	830
Health Care Access	3,099	3,541	5,565	5,200	10,765
Federal Tanf	176	222	222	222	444
Statutory Appropriations					
Special Revenue	10,996	12,987	12,236	12,101	24,337
Federal	1,019	1,157	1,162	1,167	2,329
Total	**47,031**	**71,890**	**66,694**	**66,082**	**132,776**
Expenditures by Category					
Total Compensation	28,021	31,110	31,561	31,536	63,097
Other Operating Expenses	19,010	40,780	32,672	32,085	64,757
Transfers	0	0	2,461	2,461	4,922
Total	**47,031**	**71,890**	**66,694**	**66,082**	**132,776**

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Expenditures by Activity					
Financial Operations	10,760	13,795	15,730	15,590	31,320
Legal & Regulatory Operations	8,838	9,729	14,399	13,516	27,915
Management Operations	3,758	4,041	3,867	3,867	7,734
Technology Operations	23,675	44,325	32,698	33,109	65,807
Total	**47,031**	**71,890**	**66,694**	**66,082**	**132,776**
Full-Time Equivalents (FTE)	**426.8**	**432.6**	**459.6**	**459.6**	

Activity Description

Financial Operations manages the financial processes and reporting to support agency programs. Financial Operations assures fiscal integrity of agency programs by maintaining standards and procedures that are consistent with state and federal law and appropriate business practices.

Activity at a Glance

- Develops and manages $17.8 billion biennial budget
- Processes approximately $4.5 billion in annual receipts
- Develops financial reports and analyses for about 290 grant programs
- Manages federal Single Audit Act activities for more than 280 organizations that receive federal human services funding
- Prepares expenditure forecasts for more than 10 agency programs

Population Served

Because Financial Operations provides services to all Department of Human Services (DHS) policy and operations areas, virtually all agency clients benefit directly or indirectly.

Services Provided

Financial Operations forecasts program expenditures and revenues, prepares reports and analyses of expenditures and revenues, and prepares fiscal notes projecting the effects of policy changes. These activities include

- producing the November and February program expenditure and enrollment forecasts, such as those for Medical Assistance (MA) and the Minnesota Family Investment Program (MFIP);
- reporting and analyzing county expenditures;
- reporting and analyzing federal funding and revenues;
- preparing internal management reports on administrative and grant expenditures; and
- producing fiscal notes and other projections of the fiscal impact of policy changes.

Financial Operations provides agencywide accounting and financial support, including

- establishing financial procedure guidelines for all agency fiscal activities;
- managing accounts receivable and ensuring collection of funds from all possible sources;
- maintaining fiscal records through the Minnesota Accounting and Procurement System (MAPS) and generating, distributing, and maintaining the accounting reports on state, federal, and other funds expended by the agency; and
- updating and maintaining computer interfaces and seeking new technology to improve agency fiscal operations and to enable more efficient financial transactions with customers and business partners.

Financial Operations is responsible for development and management of the agency's biennial, supplemental, and capital budgets.

Financial Operations activities include development and management of ongoing fiscal policies and strategies to support policy objectives, meet changing federal requirements, and ensure fiscal accountability.

Financial Operations provides technical assistance to internal and external customers by

- providing resources and technical assistance for agency policy staff and county staff on grants and allocations, potential revenue enhancement programs, MAPS operations and reporting, program fiscal requirements, federal claiming, reports, and payments, and statewide program costs and revenues;
- improving our understanding of county, tribal and other local partners' perspectives through DHS-county fiscal staff exchanges; partnering with counties on the annual Association of Minnesota Social Service Accountants (MACSSA) conference; participating in regional and topical meetings with counties, tribes, collaboratives, and other partners; attending MACSSA committees, best practices, and other groups; and
- improving fiscal education and training opportunities for agency staff, counties, tribes, and other business partners through the use of current technology, onsite visits, interactive video, and the web.

Financial Operations includes internal auditing to provide management with an independent appraisal of the agency's fiscal management and programmatic controls. It is a managerial control that functions by measuring and evaluating the effectiveness of other department control mechanisms. Activities include:

- evaluating the agency's system of internal controls, conducting management-requested operational reviews, and auditing counties, grantees, contractors, and vendors for fiscal and compliance requirements;
- investigating suspected or alleged misuse of state resources;
- acting as the agency's liaison for external audit groups;
- managing the agency's federal single audit report requirements; and
- operating a computer forensic laboratory to assist the agency's Human Resources Division and other state agencies with personnel investigations.

Historical Perspective

The past 10 years have brought significant increases in the complexity of program funding and budgeting rules. For example, the Temporary Assistance for Needy Families (TANF) block grant replaced the open entitlement Aid to Families with Dependent Children (AFDC); and the Health Care Access Fund (HCAF) was created to segregate funding for MinnesotaCare from the General Fund.

Increased use of program fees and premiums and greater complexity in program funding mechanisms and requirements have all had an impact on Financial Operations' work flow, compelling greater use of technology for efficiency and development and maintenance of electronic interfaces between computer systems within the department and between DHS, statewide, and county systems. Expectations have increased for the use of electronic transfers of funds among DHS business partners.

The Internal Audits Office was established in November 1995 to provide the department with an independent evaluation of its operations and to coordinate mandatory audit requirements for federal program funds. More recently, the office has developed a computer forensic service to assist DHS' Human Resource Division and other state agencies in personnel investigations.

Key Measures

⇒ Number and percentage of Department Results measures that show improvement and progress toward reaching targets (for those with targets).

More information on Department of Human Services measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

Financial Operations is funded primarily with appropriations from the General Fund and Health Care Access Fund and from federal funds.

Contact

For more information about Financial Operations, contact

- Finance and Management Operations Assistant Commissioner Dennis W. Erickson, (651) 296-6635
- Management and Budget Office Director Jane Wilcox Hardwick, (651) 297-8051
- Financial Management Acting Director Phillip Ohman, (651) 296-2780
- Reports and Forecasts Director George Hoffman, (651) 296-6154
- Office of Internal Audits Director David Ehrhardt, (651) 282-9996

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	10,135	10,049	10,049	10,049	20,098
Subtotal - Forecast Base	10,135	10,049	10,049	10,049	20,098
Governor's Recommendations					
MDE Transfer Accounting Solutions		0	802	802	1,604
Total	**10,135**	**10,049**	**10,851**	**10,851**	**21,702**
Health Care Access					
Current Appropriation	828	696	696	696	1,392
Subtotal - Forecast Base	828	696	696	696	1,392
Governor's Recommendations					
Better Manage Health Care Costs		0	117	141	258
Total	**828**	**696**	**813**	**837**	**1,650**
Federal Tanf					
Current Appropriation	122	122	122	122	244
Subtotal - Forecast Base	122	122	122	122	244
Total	**122**	**122**	**122**	**122**	**244**
Expenditures by Fund					
Direct Appropriations					
General	6,934	8,760	10,851	10,851	21,702
Health Care Access	593	696	813	837	1,650
Federal Tanf	76	122	122	122	244
Statutory Appropriations					
Special Revenue	2,968	4,002	3,724	3,555	7,279
Federal	189	215	220	225	445
Total	**10,760**	**13,795**	**15,730**	**15,590**	**31,320**
Expenditures by Category					
Total Compensation	9,400	9,879	9,889	9,894	19,783
Other Operating Expenses	1,360	3,916	5,716	5,571	11,287
Transfers	0	0	125	125	250
Total	**10,760**	**13,795**	**15,730**	**15,590**	**31,320**
Full-Time Equivalents (FTE)	**139.8**	**141.1**	**141.1**	**141.1**	

Activity Description

Legal and Regulatory Operations maintains legal standards by which the agency operates and by which clients gain access to services. Appeals and Regulations develops and implements statutory and regulatory standards for fair hearings, contested case hearings, and contracting; provides legal analysis and/or advice regarding data privacy and contract development/management; writes rules that define client benefits; and publishes bulletins concerning program changes and other issues affecting agency clients and programs. The Licensing Division licenses programs that serve children and vulnerable adults, conducts background studies on individuals who have direct contact with clients, and investigates allegations of maltreatment.

Activity at a Glance

- Regulates 27,000 licensed programs
- Conducts 170,000 background studies
- Investigates 700 maltreatment allegations
- Reviews and approves more than 1,000 contracts
- Conducts more than 6,000 administrative fair hearings
- Responds to more than 500 data privacy inquiries

Population Served

Because Legal and Regulatory Operations supports all Department of Human Services (DHS) policy areas, virtually all agency clients are served directly or indirectly.

Direct client contact includes meeting with clients through the fair hearing process and through licensing a wide range of services, including those for people with mental illness, chemical dependency, and developmental disabilities, and for providers of foster care, child placement and adoption services, and child care. Indirect contact includes county licensing oversight and approving grant contracts for delivery of client services.

Services Provided

Appeals resolution and regulations development include

- resolving disputes with clients, license holders, and long-term care facilities by
  - ⇒ conducting more than 6,000 administrative fair hearings annually for applicants and recipients of service whose benefits have been denied, reduced, or terminated;
  - ⇒ resolving more than 80 appeals annually by applicants denied licenses or by providers whose licenses are suspended or revoked; and
  - ⇒ handling appeals for Medical Assistance (MA) and General Assistance Medical Care service providers, including any rate appeals by more than 400 MA long-term care providers; and medical assessment appeals by more than 150 hospitals.
- providing legal support and rule-making activities for all department programs;
- overseeing litigation in collaboration with the Attorney General's Office;
- responding to more than 1,000 requests for data annually; and
- managing grants and contracts for department services.

Licensing activities include

- licensing, monitoring, and investigating 27,000 human services programs at any given time, including issuing approximately 5,000 new licenses annually;
- conducting approximately 170,000 background studies on people who provide direct contact services in programs licensed by DHS and the Minnesota Department of Health (MDH);
- investigating approximately 1,400 complaints about the quality of services provided in licensed programs, including approximately 700 investigations of abuse or neglect of children and vulnerable adults;
- issuing approximately 500 licensing sanctions per year;
- processing approximately 1,700 requests for administrative reconsideration of disqualifications based on background study information, maltreatment investigation findings, and licensing actions; and
- defending licensing decisions in fair hearings, contested case hearings, district court, and the Minnesota Court of Appeals.

Historical Perspective

The appeals and regulations work initially focused on hearings for applicants and recipients of DHS health care and economic assistance benefits. The nature of hearings has changed from relatively simple, single-issue eligibility appeals to more complicated medical and social services appeals. The department also has assumed responsibility for certain licensing and provider appeals and review of child and vulnerable adult maltreatment determinations. In addition, the number of appeals has increased dramatically in the last two years.

In 1996, the federal government passed the Health Insurance Portability Accountability Act (HIPAA), a complex federal law designed to provide protections to health care consumers and save administrative costs for health care providers. The HIPAA regulations set standards for electronic transmissions, electronic safeguards, and privacy protections for the handling of private health care information. Appeals and Regulations is responsible for ensuring DHS' implementation of and compliance with the HIPAA privacy regulations.

In 1991, the legislature enacted a background study system. In 1995 and 2001 the legislature expanded DHS' responsibility to include background studies on people providing services in programs licensed by the Minnesota departments of Health and Corrections, respectively. In 1995, the legislature transferred responsibility for many vulnerable adult maltreatment investigations from counties to DHS, and, in 1997, transferred responsibility for many maltreatment of minors investigations from counties to DHS. Regulatory simplification and the press for greater consistency across agencies has led to efforts like the current interagency project to implement the "umbrella rule" that establishes similar standards for child placement in out-of-home settings whether those children come into human services or corrections programs. New chemical dependency licensing rules will be effective in January 2005, a newly designed adult mental health system is unfolding, the number of new programs is increasing, and due process requirements continue to expand.

All aspects of Legal and Regulatory Operations have been affected significantly by two trends: more and faster-changing types of service models, which challenge traditional licensing and regulatory approaches; and the demands of clients, business partners, and DHS staff for more use of electronic government services for basic information dissemination and for interactive business transactions.

Key Measures

⇒ Number and percentage of Department Results measures that show improvement and progress toward reaching targets (for those with targets).

More information on Department of Human Services measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

Legal and Regulatory Operations is funded primarily with appropriations from the General Fund, Health Care Access Fund, and state government Special Revenue Fund, from federal funds, and from fees.

Contact

For more information about Legal and Regulatory Operations, contact

- Finance and Management Operations Assistant Commissioner Dennis W. Erickson, (651) 296-6635
- Appeals and Regulations Director Rae Bly, (651) 297-1489
- Licensing Director Jerry Kerber, (651) 296-4473

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: AGENCY MANAGEMENT
Activity: LEGAL & REGULATORY OPERATIONS

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	7,896	7,635	7,635	7,635	15,270
Subtotal - Forecast Base	7,896	7,635	7,635	7,635	15,270
Governor's Recommendations					
Licensing Requirements		0	1,212	1,036	2,248
Fair Hearing Requirements		0	1,013	842	1,855
Total	**7,896**	**7,635**	**9,860**	**9,513**	**19,373**
State Government Spec Revenue					
Current Appropriation	415	415	415	415	830
Subtotal - Forecast Base	415	415	415	415	830
Total	**415**	**415**	**415**	**415**	**830**
Health Care Access					
Current Appropriation	244	244	244	244	488
Subtotal - Forecast Base	244	244	244	244	488
Governor's Recommendations					
Restructure MHCP Eligibility		0	436	0	436
Better Manage Health Care Costs		0	75	75	150
Total	**244**	**244**	**755**	**319**	**1,074**
Federal Tanf					
Current Appropriation	100	100	100	100	200
Subtotal - Forecast Base	100	100	100	100	200
Total	**100**	**100**	**100**	**100**	**200**
Expenditures by Fund					
Direct Appropriations					
General	5,528	5,794	9,860	9,513	19,373
State Government Spec Revenue	415	415	415	415	830
Health Care Access	249	244	755	319	1,074
Federal Tanf	100	100	100	100	200
Statutory Appropriations					
Special Revenue	1,716	2,234	2,327	2,227	4,554
Federal	830	942	942	942	1,884
Total	**8,838**	**9,729**	**14,399**	**13,516**	**27,915**
Expenditures by Category					
Total Compensation	7,467	8,076	8,742	8,642	17,384
Other Operating Expenses	1,371	1,653	3,321	2,538	5,859
Transfers	0	0	2,336	2,336	4,672
Total	**8,838**	**9,729**	**14,399**	**13,516**	**27,915**
Full-Time Equivalents (FTE)	**121.8**	**122.9**	**149.9**	**149.9**	

Activity Description

Management Operations promotes and supports workplace performance through its responsibility for the department's public policy direction, external relations, communication oversight, equal employment opportunity and affirmative action plan implementation, and human resources activities.

Activity at a Glance

- Provides agency-wide decision making
- Provides human resources support for more than 6,600 staff
- Provides personnel services to 75 counties

Population Served

Because Management Operations supports all Department of Human Services (DHS) policy and operations areas, virtually all agency businesses and clients are served directly or indirectly.

Services Provided

Management Operations provides

- agency leadership, public policy direction, and legislative liaison activity;
- communication oversight for interactions with clients, business partners, the media, legislators and their staff; other state agencies, counties, tribes, and the federal government;
- human resources management services for DHS central office, state operated services, and 75 counties including
  - ⇒ personnel recruitment, selection, redeployment, compensation, classification, performance evaluation, and training;
  - ⇒ labor relations, grievance arbitration, and negotiations of supplemental agreements and memoranda of understanding; and
  - ⇒ health, safety, wellness, workers compensation, and complaint investigation activities;
- development of a culturally competent workforce through equal opportunity and affirmative action plan implementation, Americans with Disabilities Act coordination, diversity training, and civil rights enforcement;
- coordination of department communication efforts by
  - ⇒ responding to inquiries from news media;
  - ⇒ preparing information that helps the public understand department services and human services policies; and
  - ⇒ publishing all news releases, news tips, and fact sheets on the department's website;
- coordination of ongoing consultation with tribal governments and, where appropriate, state and federal agencies, relating to the implementation of DHS services on Indian reservations and urban Indian communities;
- customer relations activities for the department to ensure that constituents receive timely and helpful responses to inquiries and requests for assistance;
- orchestration of agencywide policy development so that it synchronizes with the direction of the department's senior management team, the commissioner, and the governor; and
- legislative activities include managing the department's legislative process, working with staff on the development of human services proposals, and following the sequence of human services-related legislation from introduction through final actions.

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Historical Perspective

For human resource management, a significant development has been the past decade's increase in Minnesota's minority and non-English-speaking populations. This has increased efforts to recruit and retain staff with new language and communications skills and to develop a more diverse and culturally competent DHS work force. Other significant changes are the continued movement of state operated services from the large institutions to small community-based facilities and services, along with the increasing difficulty in recruiting health care staff and the aging of the work force.

Key Measures

⇒ Number and percentage of Department Results measures that show improvement and progress toward reaching targets (for those with targets).

⇒ Number and percentage of employees with annual performance evaluations.

More information on Department of Human Services measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

Management Operations is funded primarily from appropriations from the General Fund and Health Care Access Fund and from federal funds.

Contact

For more information about Management Operations, contact

- Deputy Commissioner Lynda Boudreau, (651) 215-6267
- Assistant to the Commissioner Lynne Singelmann, (651) 296-6627
- Communications Director Terry Gunderson, (651) 296-4416
- Human Resources Director Martha J. Watson, (651) 296-8067
- Legislative Coordinator Steve Barta, (651) 296-5685
- Tribal Relations Coordinator Vernon Laplante, (651) 296-4606
- Equal Employment, Affirmative Action, and Civil Rights Director Mary Jean Turinia-Anderson, (651) 296-3510

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	3,570	3,281	3,281	3,281	6,562
Subtotal - Forecast Base	3,570	3,281	3,281	3,281	6,562
Total	**3,570**	**3,281**	**3,281**	**3,281**	**6,562**
Health Care Access					
Current Appropriation	68	68	68	68	136
Subtotal - Forecast Base	68	68	68	68	136
Total	**68**	**68**	**68**	**68**	**136**
Expenditures by Fund					
Direct Appropriations					
General	3,160	3,455	3,281	3,281	6,562
Health Care Access	78	68	68	68	136
Statutory Appropriations					
Special Revenue	520	518	518	518	1,036
Total	**3,758**	**4,041**	**3,867**	**3,867**	**7,734**
Expenditures by Category					
Total Compensation	3,416	3,348	3,348	3,348	6,696
Other Operating Expenses	342	693	519	519	1,038
Total	**3,758**	**4,041**	**3,867**	**3,867**	**7,734**
Full-Time Equivalents (FTE)	**47.3**	**46.6**	**46.6**	**46.6**	

Activity Description

Technology Operations promotes and supports workplace performance through the department's physical facility, video and telephone communications, and technical infrastructure, working closely with programs and operations to ensure a solid foundation for future technological development.

Population Served

Technology Operations provides services to all Department of Human Services (DHS) policy and operations areas. All agency programs, human services providers, and clients benefit directly or indirectly.

Activity at a Glance

- Provides desktop support to more than 5,000 users
- Maintains DHS computer network and website
- Coordinates cross-agency technology issues with Office of Technology and Intertech
- Supports the agency's data warehouse and executive information system
- Manages eight central-office locations and 45 locations throughout Minnesota

Services Provided

Technology Operations provides agency-wide information technology direction and support and management operations.

⇒ Technology planning and oversight. Central Information Technology services include the provision of enterprise-wide (including the local human services delivery system) technology vision and planning with a focus on efficiency, improved access and better client outcomes, best investments for future upgrades, and appropriate compatibility among components of the larger system.

⇒ Central Information Technology oversees the agency's technology infrastructure and security, centralized data storage and servers, electronic government services, and coordinates department-wide technology projects such as Health Insurance Portability and Accountability Act (HIPAA) implementation. This activity includes systems architecture planning and design, leadership for strategic information resources management, consultation on improving business strategies through technology; and maintaining awareness of new technology.

⇒ Technology security. Central Information Technology assures that information is secured in a manner consistent with legal requirements and provides for business continuity and disaster recovery. This includes establishing technology security policies and procedures, architecture standards, risk analyses, and awareness and training consistent with an overall security strategy. Central Information Technology provides operational security intrusion surveillance and detection.

⇒ Agency-wide network. Central Information Technology maintains an agency-wide data network and e-mail system with servers and data storage. This requires establishing hardware and software standards, and installing and supporting desktop hardware and software.

⇒ Application development and web access. This activity includes consultation and development of applications to support programs; the provision of internet access to agency programs and information for citizens and clients, business partners, and employees; and supporting program management by maintaining a warehouse of data extracted from multiple agency systems as part of an executive information system.

⇒ Management operations. Management Operations provides

- visual communications and teleconferencing network development for the agency and human services business partners;
- telephone systems and related interactive response technology
- facility management and building security;
- purchasing services, inventory control, and property management; and
- translation and publishing of documents, including vital documents for clients with limited English proficiency (LEP).

Historical Perspective

Citizens and clients, business partners, and other levels of government expect that state government services will be conducted through increasingly sophisticated electronic means – including web technology, sophisticated telephone systems, and improved videoconferencing as examples.

Consistent with legislation enacted in 2001, the department is in the process of consolidating its eight central office locations into three, including one new building that the state will lease-to-own over 20 years. The consolidated space will more appropriately support agency work efficiencies and technology needs.

Over the past three decades, the state has made investments in four major systems to support management of eligibility, benefits, and data for human services program delivery. Information about the impacts of these systems can be found in the narrative and fiscal report for the related budget activities (identified below).

⇒ The Health Care Operations budget activity of the Health Care Management program includes Medicaid Management Information System (MMIS), a Medicaid management information system that predominately provides centralized claims payment for the state's publicly funded health care programs.

⇒ The Children and Economic Assistance Operations budget activity of the Children and Economic Assistance Management program includes three major systems:

- MAXIS, an eligibility and benefits payment systems for economic assistance programs (including MN Electronic Child Care System (MEC^2)
- PRISM, a federally mandated computer system to support child support enforcement activities.
- Social Service Information System (SSIS), the social services information system.

In addition, expenditure information is provided annually to the chairs of health and human services finance committees.

Key Measures

Number and percentage of Department Results measures which show improvement and progress toward reaching targets (for those with targets).

More information on Department of Human Services measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

Technology Operations is funded with appropriations from the General Fund and Health Care Access Fund and federal matching funds.

Contact

For more information about Technology Operations, contact

- Chief Information Officer Johanna Berg, (651) 296-0570
- Operations Division Director Chris Zehoski, (651) 296-0871
- Application Development and Support Director Tom Albrecht, (651) 215-9441
- Chief Information Security Officer Barry Caplin, (651) 297-3196
- Management Operations Director Linda Nelson (651) 296-6633

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: AGENCY MANAGEMENT
Activity: TECHNOLOGY OPERATIONS

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	18,353	18,565	18,565	18,565	37,130
Subtotal - Forecast Base	18,353	18,565	18,565	18,565	37,130
Governor's Recommendations					
Facilities Consolidation Lease Costs		0	4,537	4,767	9,304
Total	**18,353**	**18,565**	**23,102**	**23,332**	**46,434**
Health Care Access					
Current Appropriation	2,533	2,533	2,533	2,533	5,066
Subtotal - Forecast Base	2,533	2,533	2,533	2,533	5,066
Governor's Recommendations					
Facilities Consolidation Lease Costs		0	1,396	1,443	2,839
Total	**2,533**	**2,533**	**3,929**	**3,976**	**7,905**
Expenditures by Fund					
Direct Appropriations					
General	15,704	35,559	23,102	23,332	46,434
Health Care Access	2,179	2,533	3,929	3,976	7,905
Statutory Appropriations					
Special Revenue	5,792	6,233	5,667	5,801	11,468
Total	**23,675**	**44,325**	**32,698**	**33,109**	**65,807**
Expenditures by Category					
Total Compensation	7,738	9,807	9,582	9,652	19,234
Other Operating Expenses	15,937	34,518	23,116	23,457	46,573
Total	**23,675**	**44,325**	**32,698**	**33,109**	**65,807**
Full-Time Equivalents (FTE)	**117.9**	**122.0**	**122.0**	**122.0**	

Program Description

This program contains the department's revenue and pass through expenditures. These revenues and pass-through expenditures involve complex inter-fund accounting transactions that often result in duplicate data within the state's standard biennial budget system reports. Isolating the results of these transactions within the Revenue and Pass-Through Program simplifies the fiscal pages for the department's other programs and activities. For example, to not skew the Child Support Enforcement Grant budget activity, the department's $500 million annual child support collection (revenue) and payment (pass-through expenditure) activity is reflected here.

Revenues

Department of Human Services (DHS) collects or processes revenues in excess of $4 billion annually. State law determines whether this revenue is *dedicated revenue* to the department (i.e. earmarked for specific programs) or *non-dedicated revenue* to the state.

Approximately 80% of the annual revenue is dedicated revenue. Examples include child support collections, federal grants, program premiums (co-pays), recoveries and refunds, cost of care billings, fees and federal administrative reimbursement.

Approximately 20% of the annual revenue is non-dedicated revenue. Examples include surcharges, recoveries and refunds, cost of care billings, fees and federal administrative reimbursement.

Pass-Through

The department's pass-through expenditures are approximately $1 billion annually. Generally, pass-through expenditures are the result of transactions between funds. Examples include child support payments, transfers and federal administrative reimbursement.

Federal Administrative Reimbursement

Eligible state administrative costs are reimbursed from federal grants at various percentages, known as the federal financial participation (FFP) rates. Not all state administrative costs are eligible for federal reimbursement. For example, expenditures that support state-only programs do not earn FFP.

The department maintains a federally approved cost allocation plan that draws reimbursement for the federal share of state administrative expenditures. In this case, state administrative expenditures are defined to state costs (including the DHS central office) as well as county/local costs.

The department's central office federal administrative reimbursement exceeds $100 million annually. Unless otherwise specified in state law, federal administrative reimbursement earned on General Fund and Health Care Access Fund expenditures is non-dedicated revenue to the state. State law dedicates the federal administrative reimbursement earned on major system and other selected expenditures to the department. Approximately one-third of federal administrative reimbursement revenue is non-dedicated revenue to the General Fund, while DHS retains roughly two-thirds of such revenue.

Historically, the DHS central office has drawn the following average FFP rates, based on cost allocation within the state fund in which the administrative expenditure is incurred:

General Fund/ Health Care Access Fund	40%
Major Systems – PRISM	66%
Major Systems – Social Services Information System (SSIS)	50%
Major Systems – MAXIS	45%
Major Systems – Medicaid Management Information System (MMIS)	65%

For simplicity and consistency, DHS budget initiatives and fiscal note estimates are based on these historic central office average FFP rates.

HUMAN SERVICES DEPT

Program: REVENUE & PASS THROUGH

Activity: REVENUE & PASS THROUGH

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
Federal Tanf					
Current Appropriation	56,657	57,289	57,289	57,289	114,578
Technical Adjustments					
Current Law Base Change			3,555	55	3,610
End-of-session Estimate			701	1,645	2,346
November Forecast Adjustment		(147)	(137)	(23)	(160)
Subtotal - Forecast Base	56,657	57,142	61,408	58,966	120,374
Total	**56,657**	**57,142**	**61,408**	**58,966**	**120,374**
Expenditures by Fund					
Direct Appropriations					
Federal Tanf	52,318	57,142	61,408	58,966	120,374
Statutory Appropriations					
General	18	16	16	16	32
Special Revenue	5,753	5,710	4,303	4,461	8,764
Federal	342,593	335,450	323,870	326,929	650,799
Miscellaneous Agency	588,052	794,639	794,639	794,639	1,589,278
Total	**988,734**	**1,192,957**	**1,184,236**	**1,185,011**	**2,369,247**
Expenditures by Category					
Other Operating Expenses	121,903	114,517	102,932	105,980	208,912
Payments To Individuals	72	178,977	178,977	178,977	357,954
Local Assistance	273,713	279,190	283,261	280,819	564,080
Other Financial Transactions	593,046	620,273	619,066	619,235	1,238,301
Total	**988,734**	**1,192,957**	**1,184,236**	**1,185,011**	**2,369,247**

Program Description

The purpose of the Children's and Economic Assistance Grants program is to provide cash, food support, child care, housing assistance, job training, and work-related services to increase the ability of families and individuals to transition to economic stability and to keep children safe and support their development.

Budget Activities Included:

⇒ Minneota Family Investment Policy/Diversionary Work Program (MFIP/DWP) Grants
⇒ Support Services Grants
⇒ MFIP Child Care Assistance Grants
⇒ Basic Sliding Fee (BSF) Child Care Assistance Grants
⇒ Child Care Development Grants
⇒ Child Support Enforcement Grants
⇒ Children's Services Grants
⇒ Children and Community Services Grants
⇒ General Assistance Grants
⇒ Minnesota Supplemental Aid Grants
⇒ Group Residential Housing Grants
⇒ Refugee Services Grants
⇒ Other Children's and Economic Assistance Grants

HUMAN SERVICES DEPT

Program: CHILDREN & ECONOMIC ASST GR

Program Summary

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	331,004	292,619	292,619	292,619	585,238
Technical Adjustments					
Current Law Base Change			39,400	43,944	83,344
End-of-session Estimate			(4,132)	7,337	3,205
Fund Changes/consolidation			225	225	450
November Forecast Adjustment		7,774	2,882	(3,943)	(1,061)
Transfers Between Agencies			123,473	131,479	254,952
Subtotal - Forecast Base	331,004	300,393	454,467	471,661	926,128
Governor's Recommendations					
American Indian Child Welfare Project		0	0	4,838	4,838
Adoption Assistance & RCA Approp. Adj.		0	(1,340)	(1,491)	(2,831)
Prevent Homelessness After FC		0	1,085	1,085	2,170
Supp Housing Serv for Homeless		0	5,000	5,000	10,000
Delay Proj of Reg'l Significance		0	(25,000)	(25,000)	(50,000)
Freeze Max. Child Care Rates		0	(33,351)	(37,264)	(70,615)
MDE Transfer Accounting Solutions		0	3,340	3,340	6,680
Finalize 2003 TANF Refinancing		0	(6,692)	(3,192)	(9,884)
Total	**331,004**	**300,393**	**397,509**	**418,977**	**816,486**
Federal Tanf					
Current Appropriation	212,844	219,552	209,264	209,264	418,528
Technical Adjustments					
Current Law Base Change			(87)	(49)	(136)
End-of-session Estimate			3,344	(3,049)	295
November Forecast Adjustment		(10,141)	8,964	15,153	24,117
Subtotal - Forecast Base	212,844	209,411	221,485	221,319	442,804
Total	**212,844**	**209,411**	**221,485**	**221,319**	**442,804**
Expenditures by Fund					
Direct Appropriations					
General	431,894	403,329	397,509	418,977	816,486
Federal Tanf	201,869	209,475	221,485	221,319	442,804
Statutory Appropriations					
General	7,062	9,941	10,251	10,534	20,785
Special Revenue	6,232	12,519	7,216	6,650	13,866
Federal	442,030	476,754	460,682	457,769	918,451
Miscellaneous Agency	15,535	14,965	14,863	14,862	29,725
Gift	14	58	58	58	116
Total	**1,104,636**	**1,127,041**	**1,112,064**	**1,130,169**	**2,242,233**

HUMAN SERVICES DEPT

Program: CHILDREN & ECONOMIC ASST GR

Program Summary

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Expenditures by Category					
Other Operating Expenses	1,987	1,125	768	454	1,222
Payments To Individuals	629,035	637,453	616,098	627,447	1,243,545
Local Assistance	456,877	473,498	480,335	487,406	967,741
Other Financial Transactions	16,737	14,965	14,863	14,862	29,725
Total	**1,104,636**	**1,127,041**	**1,112,064**	**1,130,169**	**2,242,233**
Expenditures by Activity					
Mfip/Dwp Gr	327,094	311,610	306,315	307,041	613,356
Support Services Gr	98,946	123,182	112,762	112,818	225,580
Mfip Child Care Assistance Gr	100,337	101,118	96,852	100,597	197,449
Bsf Child Care Assistance Gr	72,332	78,017	77,871	78,615	156,486
Child Care Development Gr	11,878	11,797	10,868	10,097	20,965
Child Support Enforcement Gr	3,999	4,460	4,424	4,403	8,827
Childrens Services Gr	97,248	114,274	109,679	118,805	228,484
Children & Community Svs Gr	112,681	94,347	101,234	101,234	202,468
General Assistance Gr	28,929	31,049	31,825	32,607	64,432
Mn Supplemental Aid Gr	28,861	30,000	30,725	31,255	61,980
Group Resident Housing Gr	87,242	87,522	85,038	90,560	175,598
Refugee Services Gr	9,569	11,534	11,533	11,533	23,066
Other Children & Econ Asst Gr	125,520	128,131	132,938	130,604	263,542
Total	**1,104,636**	**1,127,041**	**1,112,064**	**1,130,169**	**2,242,233**

Activity Description

Minnesota Family Investment Program (MFIP) and the Diversionary Work Program (DWP) Grants pays for cash grants for families participating in the MFIP and the DWP and for food assistance for MFIP families. MFIP is Minnesota's program for the federal Temporary Assistance to Needy Families (TANF) block grant, which replaced Aid to Families with Dependent Children (AFDC) in 1996. DWP is a short-term, work-focused program to help families avoid longer-term assistance.

Activity at a Glance

- Provides assistance for 45,000 families (or 129,000 people) a month-- two-thirds of which are children

Population Served

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

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

DWP, which began 7-1-04, now includes many of the families that would have in the past applied for MFIP. Families applying for DWP must develop and sign an employment plan before they can receive any assistance. After families have an employment plan, they can receive financial assistance to meet their basic needs and other supports, such as food, child care, and health care assistance. Shelter and utilities costs are paid directly to landlords, mortgage companies, or utility companies. Participation in the program does not count against the 60-month life-time limit on cash assistance. Some families are excluded from DWP, including those with disabled adults or children, adults over 60, teen parents finishing high school, child-only cases, and families that have received TANF or MFIP in the past 12 months or for 60 months.

Services Provided

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

Parents on MFIP, who fail to work or follow through with activities to support their families, have their assistance cut by 10%, or more depending upon how long they have been out of compliance. Parents on DWP who do not cooperate with their employment plan will have their cases closed and are not eligible for cash assistance until their four months of DWP ends.

Historical Perspective

MFIP was initially piloted in seven counties as a state welfare reform effort. After passage of the federal welfare reform law, MFIP was implemented statewide in 1998 as the state's TANF program. MFIP replaced AFDC and includes employment and training and food support. Congress is expected to reauthorize the TANF law in 2005, possibly requiring changes to MFIP.

Minnesota has experienced national success with MFIP. More than two-thirds, or 68%, of families on assistance in the winter of 2000 were off assistance or were on MFIP and working 30 hours a week three years later in 2003. The population served by MFIP remains vulnerable to economic shifts. Because of the slumping economy, the MFIP caseload increased from 40,700 families in FY 2001 to 44,800 families in FY 2003. It appears that the number of families applying for assistance has stabilized during the first six months of 2004.

DWP was enacted by the 2003 legislature and implemented in July 2004. An average of 1,000 cases a month are expected to be diverted to the new program. After the phase-in, the monthly average caseload for DWP is projected to be 3,500 families. Some of these families are expected to transition to MFIP after completing four months of DWP.

Key Measures

⇒ MFIP Self-Support Index (percent of adults working 30+ hours or off MFIP cash assistance three years later)
⇒ Percent of adults participating in work activities for specified hours per week

More information on Department of Human Services measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

MFI/DWP Grants is funded primarily with appropriations from the General Fund and from the federal TANF block grant, which replaced AFDC in 1996.

Contact

For more information on the Minnesota Family Investment Program, contact

- Assistant Commissioner Chuck Johnson, (651) 297-4727
- Transition to Economic Stability Division Acting Director Ann Sessoms, (651) 297-7515

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	53,818	43,942	43,942	43,942	87,884
Technical Adjustments					
End-of-session Estimate			(10,275)	(6,317)	(16,592)
November Forecast Adjustment		15,695	(735)	(5,686)	(6,421)
Subtotal - Forecast Base	53,818	59,637	32,932	31,939	64,871
Total	**53,818**	**59,637**	**32,932**	**31,939**	**64,871**
Federal Tanf					
Current Appropriation	114,370	106,583	106,583	106,583	213,166
Technical Adjustments					
End-of-session Estimate			3,344	(3,049)	295
November Forecast Adjustment		(10,141)	8,964	15,153	24,117
Subtotal - Forecast Base	114,370	96,442	118,891	118,687	237,578
Total	**114,370**	**96,442**	**118,891**	**118,687**	**237,578**
Expenditures by Fund					
Direct Appropriations					
General	53,818	59,637	32,932	31,939	64,871
Federal Tanf	113,247	96,442	118,891	118,687	237,578
Statutory Appropriations					
General	3,377	3,798	4,108	4,391	8,499
Federal	141,117	136,768	135,521	137,162	272,683
Miscellaneous Agency	15,535	14,965	14,863	14,862	29,725
Total	**327,094**	**311,610**	**306,315**	**307,041**	**613,356**
Expenditures by Category					
Payments To Individuals	303,533	289,359	284,338	285,083	569,421
Local Assistance	6,824	7,286	7,114	7,096	14,210
Other Financial Transactions	16,737	14,965	14,863	14,862	29,725
Total	**327,094**	**311,610**	**306,315**	**307,041**	**613,356**

Activity Description

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

Activity at a Glance

- Provides MFIP employment services to 13,000 people per month
- Provides Food Stamp employment services to 1,700 people per month

Population Served

This activity serves two core groups

- participants in MFIP and DWP and
- recipients of food stamps, or food support, through the Food Support Employment and Training (FSET) program.

Services Provided

Support Services Grants include the MFIP consolidated funds, which are allocated to counties and tribes, and FSET funding. This includes work programs that are co-managed by the Department of Human Services (DHS) and the Minnesota Department of Employment and Economic Development (DEED). DEED oversees state workforce centers that work with county agencies to evaluate the needs of each recipient and develop an individualized employment plan.

County and local employment service providers refer participants to services including

- job search, job counseling, job interview skills, skill development, and training services;
- adult basic education, intensive work literacy, high school completion classes, general equivalency diploma(GED)/high school equivalency coaching, and training currently limited to 24 months;
- English proficiency training;
- county emergency need programs that help low-income families with housing crises;
- assistance and referral to other services such as child care, medical benefits programs, and chemical dependency and mental health services; and
- small business development (for a small group of recipients who may be good candidates to become self-employed).

Historical Perspective

The 2003 legislature created the MFIP consolidated fund, combining funding for a number of family support programs for MFIP participants. This allows counties, tribes, and nonprofits to continue successful approaches to moving MFIP families to work. A number of separate programs, including Emergency Assistance for families, were repealed. Service agreements for each county set outcomes, which include county performance measures.

Key Measures

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

⇒ Percent of adults participating in work activities for specified hours per week

More information on Department of Human Services measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

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

Contact

For more information on Support Services Grants, contact

- Assistant Commissioner Chuck Johnson, (651) 297-4727
- Transition to Economic Stability Division Acting Director Ann Sessoms, (651) 297-7515

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: CHILDREN & ECONOMIC ASST GR
Activity: SUPPORT SERVICES GR

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	8,666	8,678	8,678	8,678	17,356
Technical Adjustments					
Current Law Base Change			19	37	56
Subtotal - Forecast Base	8,666	8,678	8,697	8,715	17,412
Total	**8,666**	**8,678**	**8,697**	**8,715**	**17,412**
Federal Tanf					
Current Appropriation	98,474	112,969	102,681	102,681	205,362
Technical Adjustments					
Current Law Base Change			(87)	(49)	(136)
Subtotal - Forecast Base	98,474	112,969	102,594	102,632	205,226
Total	**98,474**	**112,969**	**102,594**	**102,632**	**205,226**
Expenditures by Fund					
Direct Appropriations					
General	8,657	8,678	8,697	8,715	17,412
Federal Tanf	88,622	113,033	102,594	102,632	205,226
Statutory Appropriations					
Federal	1,667	1,471	1,471	1,471	2,942
Total	**98,946**	**123,182**	**112,762**	**112,818**	**225,580**
Expenditures by Category					
Other Operating Expenses	251	250	0	0	0
Payments To Individuals	16,626	27,142	27,161	27,179	54,340
Local Assistance	82,069	95,790	85,601	85,639	171,240
Total	**98,946**	**123,182**	**112,762**	**112,818**	**225,580**

Activity Description

The Minnesota Family Investment Program (MFIP) 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. This program is supervised by the Department of Human Services and administered by county social services agencies.

Activity at a Glance

- Purchases child care for nearly 19,000 children in 10,000 families each month

Population Served

Families who participate in welfare reform activities are served through the (MFIP) child care program which includes MFIP and Transition Year (TY) subprograms.

Services Provided

The following families are eligible to receive MFIP or TY child care assistance: 1) MFIP and Diversionary Work Program (DWP) families who are employed or pursuing employment, or participating in employment, training, or social services activities authorized in an approved employment services plan; and 2) employed families who are in their first year off MFIP or DWP (transition year).

Historical Perspective

MFIP child care was called AFDC (Aid to Families with Dependent Children) child care and funded by federal Title IV(A) funds prior to the 1996 federal welfare reform act. Demand for child care assistance has increased as parents participating in welfare reform are required to be employed or looking for work. The total number of families served has increased from 9,800 in FY 1999 to 10,200 in FY 2003. Total expenditures have increased from $77 million to $117 million over those years.

Key Measures

⇒ Percent of child care assistance leavers who are still employed six months later (under development).

⇒ Percent of young children in quality early childhood care and education settings who are ready for school as measured by an observational performance assessment (under development).

More information on Department of Human Services measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

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

Contact

For more information on Employment and Training Grants, contact

- Assistant Commissioner Chuck Johnson, (651) 297-4727
- Transition to Economic Stability Division Acting Director Ann Sessoms, (651) 297-7515
- Child Care Assistance Manager Cherie Kotilinek, (651) 284-4203

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	0	0	0	0	0
Technical Adjustments					
November Forecast Adjustment		(14,988)	3,676	2,479	6,155
Transfers Between Agencies			82,555	91,061	173,616
Subtotal - Forecast Base	0	(14,988)	86,231	93,540	179,771
Governor's Recommendations					
Freeze Max. Child Care Rates		0	(21,910)	(29,850)	(51,760)
Finalize 2003 TANF Refinancing		0	(6,692)	(3,192)	(9,884)
Total	**0**	**-14,988**	**57,629**	**60,498**	**118,127**
Expenditures by Fund					
Direct Appropriations					
General	67,935	53,647	57,629	60,498	118,127
Statutory Appropriations					
Federal	32,402	47,471	39,223	40,099	79,322
Total	**100,337**	**101,118**	**96,852**	**100,597**	**197,449**
Expenditures by Category					
Payments To Individuals	12,328	12,335	5,000	5,000	10,000
Local Assistance	88,009	88,783	91,852	95,597	187,449
Total	**100,337**	**101,118**	**96,852**	**100,597**	**197,449**

Activity Description

Basic Sliding Fee (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. This program is supervised by the Department of Human Services and administered by county social services agencies.

Activity at a Glance

- Purchases child care for 21,000 children in 12,500 families each month

Population Served

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

Services Provided

BSF Child Care Assistance Grants help families pay child care costs on a sliding fee basis. As family income increases, so does the amount paid by the family.

⇒ BSF child care helps pay the child care costs of low-income families not currently participating in MFIP or DWP or in their first year after leaving MFIP or DWP. Families with household income at or under 175% of the federal poverty guidelines at program entry and less than 250% of the federal poverty guidelines at program exit, who participate in authorized activities, such as employment, job search, and job training, are eligible for BSF child care.

⇒ At Home Infant Care (AHIC) allows BSF eligible families with children under one year of age to receive a subsidy for a period of up to 12 months, while staying at home with their infant (and any other children). The family receives 90% of the amount that would be paid to a licensed family child care provider for infant care in the county of the family's residence. Three percent of state funds are set aside within the BSF grant for this program.

Historical Perspective

The BSF program was developed in the 1970s as a pilot program serving 24 counties in recognition that child care was essential to the employment of low-income families. The total number of families served has increased from 11,150 in SFY 1999 to 12,500 in FY 2003, with 5,500 families on waiting lists. Total expenditures have increased from $69 million to $98 million over those years.

Key Measures

⇒ Percent of child care assistance leavers who are still employed six months later (under development).

⇒ Percent of young children in quality early childhood care and education settings who are ready for school as measured by an observational performance assessment (under development).

More information on Department of Human Services measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

BSF Child Care Assistance Grants are funded by state General Fund appropriations, federal Child Care and Development Fund (CCDF) monies (which include Temporary Assistance to Needy Families (TANF) transfer funds, county contributions, and child care support collections.

Contact

For more information on Child Care Assistance Programs, contact:

- Assistant Commissioner Maria Gomez, (651) 297-3209
- Transitions to Economic Stability Division Director Chuck Johnson, (651) 297-4727
- Child Care Assistance Manager Cherie Kotilinek, (651) 284-4203

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	0	0	0	0	0
Technical Adjustments					
Transfers Between Agencies			30,262	30,262	60,524
Subtotal - Forecast Base	0	0	30,262	30,262	60,524
Governor's Recommendations					
Freeze Max. Child Care Rates		0	(11,441)	(7,414)	(18,855)
MDE Transfer Accounting Solutions		0	3,340	3,340	6,680
Total	**0**	**0**	**22,161**	**26,188**	**48,349**
Expenditures by Fund					
Direct Appropriations					
General	29,080	18,721	22,161	26,188	48,349
Statutory Appropriations					
General	0	3,091	3,091	3,091	6,182
Special Revenue	3,340	3,340	3,340	3,340	6,680
Federal	39,912	52,865	49,279	45,996	95,275
Total	**72,332**	**78,017**	**77,871**	**78,615**	**156,486**
Expenditures by Category					
Payments To Individuals	13,685	13,919	5,000	5,000	10,000
Local Assistance	58,647	64,098	72,871	73,615	146,486
Total	**72,332**	**78,017**	**77,871**	**78,615**	**156,486**

Activity Description

Child Care Development Grants promote school readiness, healthy child development, and family self-sufficiency by improving the quality and availability of child care for Minnesota.

Activity at a Glance

- Provides over 43,000 child care referrals and over 151,000 child care consultations
- Funds 4,000 grants to providers to improve the quality and availability of child care and trains 53,000 providers
- Provides 38 loans to start or expand child care programs

Population Served

⇒ An estimated 696,800 Minnesota children ages 0 to 12 need some form of child care while their parents work.

⇒ Approximately 222,000 of these children spend time in licensed child care arrangements.

⇒ 15,251 licensed child care providers serve these children.

⇒ Relatives and friends serve approximately 400,000 children in legal, unlicensed arrangements.

Services Provided

Two primary program areas respond to needs for available, quality child care for families and provide a statewide infrastructure to assist communities in responding to these needs.

⇒ Grants to both public and private agencies
- improve the quality of early childhood care and education programs;
- recruit and train child care center staff and family child care providers; and
- develop special child care services, such as care for infants, school-age children, sick children, children with special needs, care during non-traditional hours, and culturally responsive care.

⇒ Nineteen Child Care Resource & Referral (CCR&R) sites throughout the state
- improve the supply and quality of child care;
- help parents access appropriate care and information about available child care subsidy programs;
- coordinate child care services with employers, counties, and workforce centers;
- coordinate community resources and information on child care supply, demand, and cost; and
- administer grants.

Other key elements include
- ongoing mechanisms for community-level input on programs and policies through advisory committees for major program components;
- use of research and evaluation to guide policy and program development to target resources effectively; and
- local control of grant priorities for grants administered by CCR&R sites.

Historical Perspective

The 1988 Minnesota Legislature established the Child Care Development programs to respond to increased demand for quality child care and the need for a statewide infrastructure for parents and communities to respond to these needs. Since that time, Child Care Development programs have used statewide and local-level grants to
- support child care providers in improving quality and expanding services;
- develop the child care infrastructure to provide referral services to parents and professional development, technical assistance, and facilities improvements to child care providers; and
- conduct research and evaluation to identify needs and improve program effectiveness.

Key Measures

⇒ Increase the percentage of young children in quality early childhood care and education settings who are ready for school as measured by an observational performance assessment (under development).

⇒ The percentage of families using child care referral services who report increased ability to seek and select quality child care.

More information on Department of Human Services measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

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

Contact

For more information on Child Care Development Grants, contact

- Assistant Commissioner Chuck Johnson, (651) 297-4727
- Community Partnerships Director James Huber (651) 284-4120
- Child Development Services Director Barbara Yates (651) 282-3804

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	0	0	0	0	0
Technical Adjustments					
Transfers Between Agencies			1,540	1,540	3,080
Subtotal - Forecast Base	0	0	1,540	1,540	3,080
Total	**0**	**0**	**1,540**	**1,540**	**3,080**
Expenditures by Fund					
Direct Appropriations					
General	1,144	1,314	1,540	1,540	3,080
Statutory Appropriations					
Special Revenue	35	40	0	0	0
Federal	10,699	10,443	9,328	8,557	17,885
Total	**11,878**	**11,797**	**10,868**	**10,097**	**20,965**
Expenditures by Category					
Other Operating Expenses	358	40	0	0	0
Payments To Individuals	2	13	0	0	0
Local Assistance	11,518	11,744	10,868	10,097	20,965
Total	**11,878**	**11,797**	**10,868**	**10,097**	**20,965**

Activity Description

Child Support Enforcement Grants help families receive child support, an important component in helping many families become self-sufficient and stay off welfare.

Population Served

Child Support Enforcement serves both families who receive public assistance and those who are non-public assistance clients.

Activity at a Glance

- Collects $572 million in child support
- Serves 400,000 children and parents
  - ⇒ 55,400 public assistance cases
  - ⇒ 189,500 non-public assistance cases

Services Provided

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

- establishing paternity;
- establishing and modifying orders for child support, medical support, and child care support;
- collecting and disbursing support;
- enforcing support orders, including:
  - ⇒ intercepting income tax refunds and lottery winnings when child support is not paid and investigating income sources of non-paying parents, and
  - ⇒ locating non-paying parents; and
- using various tools to collect support, including suspension of driver's licenses and various state occupational licenses for non-payment, new hire reporting by employers, and working with financial institutions to move money directly from bank accounts.

Historical Perspective

The Child Support Enforcement Program was established in 1975 under Title IV-D of the Social Security Act. The purpose of the program was to reduce public expenditures on welfare. Subsequently the program was expanded to provide services for any family requesting assistance in seeking parental support for children. Federal welfare reform legislation passed in 1996 and substantially strengthened state child support activities by establishing a national new-hire and wage-reporting system, streamlining paternity establishment and authorizing new penalties for non-payment.

In July 2004, the state began charging a monthly fee for child support services. Counties must invest the funds in child support program services.

Minnesota was granted a federal waiver in 2004 to implement a healthy marriage and responsible fatherhood demonstration project.

Although most child support cases do not currently receive public assistance, about 74% of the non-public assistance cases received public assistance at one time. Most child support is collected from wage withholding by employers.

Key Measures

⇒ Current child support collection rate

⇒ Paternity establishment rate

More information on Department of Human Services measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

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

Contact

For more information on Child Support Enforcement Grants, contact

- Assistant Commissioner Chuck Johnson, (651) 297-4727
- Child Support Enforcement Division Director Wayland Campbell, (651) 297-8232

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	3,571	3,503	3,503	3,503	7,006
Technical Adjustments					
Current Law Base Change			(248)	(248)	(496)
Subtotal - Forecast Base	3,571	3,503	3,255	3,255	6,510
Total	**3,571**	**3,503**	**3,255**	**3,255**	**6,510**
Expenditures by Fund					
Direct Appropriations					
General	3,521	3,453	3,255	3,255	6,510
Statutory Appropriations					
Special Revenue	355	861	1,024	1,024	2,048
Federal	123	146	145	124	269
Total	**3,999**	**4,460**	**4,424**	**4,403**	**8,827**
Expenditures by Category					
Other Operating Expenses	(256)	(350)	(350)	(350)	(700)
Payments To Individuals	410	425	425	425	850
Local Assistance	3,845	4,385	4,349	4,328	8,677
Total	**3,999**	**4,460**	**4,424**	**4,403**	**8,827**

Activity Description

Children's Services Grants fund statewide child welfare and community-based children's mental health services.

Activity at a Glance

Serves

- 9,400 children determined to be abused or neglected
- 17,200 children in out-of-home placements
- 20,000 children who need mental health services
- 690 children who are waiting for adoption
- 1,470 children under state guardianship
- 12,400 families through the Children's Trust Fund

Population Served

Children's Services Grants fund services for children who are at risk of abuse or neglect or who have been abused or neglected, in out-of-home placements, in need of adoption, under state guardianship, or have an emotional disturbance and need mental health services. Children's Services Grants affect the lives of

- children who are abused or neglected and need child protection services;
- children who are in out-of-home placements because they cannot live safely with their parents or need care which cannot be provided within their homes;
- children who need mental health services;
- children who are waiting for immediate adoption; and
- families through the Children's Trust Fund.

Services Provided

Children's Services Grants fund services to children and families, including adoption, child protection, homeless youth services, and children's mental health services, through counties, tribes, local service collaboratives, schools, nonprofits, and foundations to deliver services.

Children's Services Grants fund the following

- alternative response assessment and services to families referred to child protection;
- Children's Trust Fund grants to prevent child abuse and neglect;
- services for women to prevent fetal alcohol syndrome;
- recruitment of foster and adoptive families and specialized services to enable state wards to be adopted;
- Adoption Assistance for children with special needs who were under state guardianship and have been adopted;
- Relative Custody Assistance for children with special needs whose custody is transferred to relatives;
- Indian child welfare services; and
- children's community-based mental health services.

Historical Perspective

Most recently, Children's Services has focused on

- reforming the child welfare system through innovative efforts such as Minnesota Child Welfare Training System, Social Services Information System, Child Maltreatment Review Panel, County Child Welfare System reviews, Family Group Decision Making, Alternative Response Program, Children's Justice Initiative, and Citizen Review Panels;
- finding and supporting permanent families for children who cannot be reunited with their families through the Public/Private Adoption Initiative, Concurrent Permanency Planning, and Minnesota Adoption Support and Preservation Network;
- meeting the needs of children with severe emotional disturbance and their families through
  - ⇒ supporting flexible, child-and family-centered services provided by children's mental health collaboratives, and
  - ⇒ supporting the development of a statewide parent leadership network for parents of children with emotional disturbances; and
- implementing statewide mental health screening for children in the child welfare and juvenile justice systems and the expansion of the Children's Therapeutic Services and Supports (CTSS).

Children's Services has developed a set of outcome measures for child welfare services that rely on data from the Social Services Information System. These measures are used to evaluate child safety, permanency, well-being, and system activity. Specific measures have also been developed for use with each set of grantees.

Key Measures

More children will live in safe and permanent homes.

⇒ Adoption: Percent of children who were adopted in fewer than 24 months from the time of latest removal from their homes.

⇒ Recurrence: Percent of children who do not experience repeated neglect or abuse within 12 months of prior report.

⇒ Reentry: Percent of children who entered foster care who did not have a prior out-of-home placement in the previous 12 months.

⇒ Reunification: Percent of children reunified in less than 12 months from the time of the latest removal from their home.

⇒ Children's Mental Health: Children screened and referred for diagnostic assessments.

More information on Department of Human Services measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Program Funding

Children's Services Grants is funded primarily with appropriations from the General Fund and from federal funds.

Contact

For more information about Children's Services Grants, contact

- Assistant Commissioner Chuck Johnson, (651) 297-4727
- Children's Mental Health Director Glenace Edwall, (651) 215-1382
- Child Safety and Permanency Director Erin Sullivan-Sutton, (651) 296-2487

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: CHILDREN & ECONOMIC ASST GR
Activity: CHILDRENS SERVICES GR

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	30,997	35,165	35,165	35,165	70,330
Technical Adjustments					
Current Law Base Change			5,578	9,983	15,561
Subtotal - Forecast Base	30,997	35,165	40,743	45,148	85,891
Governor's Recommendations					
American Indian Child Welfare Project		0	0	4,838	4,838
Adoption Assistance & RCA Approp. Adj.		0	(1,340)	(1,491)	(2,831)
Prevent Homelessness After FC		0	1,085	1,085	2,170
Total	**30,997**	**35,165**	**40,488**	**49,580**	**90,068**
Expenditures by Fund					
Direct Appropriations					
General	33,206	40,965	40,488	49,580	90,068
Statutory Appropriations					
Special Revenue	1,348	7,920	2,552	1,986	4,538
Federal	62,680	65,331	66,581	67,181	133,762
Gift	14	58	58	58	116
Total	**97,248**	**114,274**	**109,679**	**118,805**	**228,484**
Expenditures by Category					
Other Operating Expenses	636	765	705	391	1,096
Payments To Individuals	32,715	38,518	39,301	42,932	82,233
Local Assistance	63,897	74,991	69,673	75,482	145,155
Total	**97,248**	**114,274**	**109,679**	**118,805**	**228,484**

Activity Description

The Children and Community Services Grants activity provides funding to counties to purchase or provide social services for children and families. The Children and Community Services Act (CCSA) was enacted by the 2003 legislature and consolidated 15 separate state and federal children and community services grants, including Title XX, into a single grant program.

Activity at a Glance

- Funds services in 87 counties
- Serves 350,000 people annually
- Plans services for clients who experience abuse, neglect, poverty, disability, chronic health conditions, or other factors, including ethnicity and race, that may result in poor outcomes or disparities

Population Served

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

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

Services Provided

County boards are responsible for coordinating formal and informal helping systems to best support and nurture children, adolescents, and adults within the county who meet the requirements in the act. This includes assisting individuals to function at the highest level of ability while maintaining family and community relationships.

Services focus on

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

Children and Community Services Grants support

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

Historical Perspective

The 2003 legislature approved consolidated funding to counties, which combined these grants: Community Social Services Grants, Family Preservation Grants, several children's mental health grants (Rule 78, Adolescent Services, Homeless Children, Collaborative State Wraparound, Respite Care, and Screening Pilot Grants), several child welfare grants (Crisis Nursery, Homeless Children, Children with Substance-Abusing Mothers, Children Whose Mothers Were Incarcerated, Minority Placement), Hennepin County Social Services Grants for Group Residential Housing Recipients, Social Services Supplemental Grants, Training of Criminal Justice, Title XX Social Services, and Title XX Concurrent Permanency Planning Grants. The CCSA gives counties more flexibility to ensure better outcomes for children, adolescents, and adults in need of services. The act also simplifies the planning and administrative requirements from the previous Community Social Services Act. It includes criteria for counties to limit services if CSSA funds are insufficient.

For more information about the Children and Community Services Act, see Minnesota Department of Human Services (DHS) Bulletin #03-68-10 at:
http://www.dhs.state.mn.us/main/groups/publications/documents/pub/DHS_id_004869.pdf.

Key Measures

⇒ More children will live in safe and permanent homes.

⇒ Adoption: Percent of children who were adopted in fewer than 24 months from the time of latest removal from their homes

⇒ Recurrence: Percent of children who do not experience repeated neglect or abuse within 12 months of prior report

⇒ Reentry: Percent of children who entered foster care who did not have a prior out-of-home placement in the previous 12 months

⇒ Reunification: Percent of children reunited in less than 12 months from the time of the latest removal from their home

⇒ Children's Mental Health early identification and intervention: Children screened and referred for diagnostic assessments

More information on Department of Human Services measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

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

Contact

For more information on Children and Community Services Grants, contact

- Assistant Commissioner Chuck Johnson, (651) 297-4727
- Community Capacity and Planning Director Ralph McQuarter, (651) 296-0942

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	80,763	59,226	59,226	59,226	118,452
Technical Adjustments					
Current Law Base Change			34,037	34,037	68,074
Fund Changes/consolidation			225	225	450
Subtotal - Forecast Base	80,763	59,226	93,488	93,488	186,976
Governor's Recommendations					
Delay Proj of Reg'l Significance		0	(25,000)	(25,000)	(50,000)
Total	**80,763**	**59,226**	**68,488**	**68,488**	**136,976**
Expenditures by Fund					
Direct Appropriations					
General	80,763	59,226	68,488	68,488	136,976
Statutory Appropriations					
Federal	31,918	35,121	32,746	32,746	65,492
Total	**112,681**	**94,347**	**101,234**	**101,234**	**202,468**
Expenditures by Category					
Local Assistance	112,681	94,347	101,234	101,234	202,468
Total	**112,681**	**94,347**	**101,234**	**101,234**	**202,468**

Activity Description

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

Activity at a Glance

- Provides 12,000 people per month with general cash assistance

Population Served

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

Services Provided

GA grants currently provide cash assistance of $203 for single people and $260 for married couples. Special funding is available when a person or family lacks basic need items for emergency situations, which threaten health or safety.

GA is temporary for some recipients while an individual overcomes an emergency situation, a temporary problem, or is waiting for approval for other forms of assistance. For others with more intractable barriers to self-support, assistance is needed for a longer term.

GA recipients are usually eligible for payment of medical costs through the General Assistance Medical Care program or the Medical Assistance program.

Historical Perspective

The Minnesota Legislature established the General Assistance Program in 1973. The original program provided assistance to low-income people who did not qualify for federal assistance. In the early 1980s, the legislature changed the program by increasing the GA grant to the current $203 for single people and $260 for married couples and by targeting assistance to people who meet certain standards of un-employability as determined and certified by a licensed physician, licensed consulting psychologist, licensed psychologist, or vocational specialist.

In 1998, families with children were moved from GA to the Minnesota Family Investment Program, immediately reducing the number of people served on GA each month from 15,000 to 11,000. Since that time, the average number of people served on GA has ranged from a low of roughly 7,800 a month in FY 2000 to the current 12,200 a month for FY 2003.

Payments for women staying in battered women's shelters were transferred out of the GA program (into the Department of Corrections' Crime Victims Services) in FY 2001.

Key Measures

⇒ Number of moves per calendar year for General Assistance/Group Residential Housing adults

More information on Department of Human Services measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

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

Contact

For more information on General Assistance Grants, contact

- Assistant Commissioner Chuck Johnson, (651) 297-4727
- Community Living Supports Division Director Janel Bush, (651) 282-5205

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	26,329	26,909	26,909	26,909	53,818
Technical Adjustments					
End-of-session Estimate			424	1,134	1,558
November Forecast Adjustment		2,140	2,492	2,564	5,056
Subtotal - Forecast Base	26,329	29,049	29,825	30,607	60,432
Total	**26,329**	**29,049**	**29,825**	**30,607**	**60,432**
Expenditures by Fund					
Direct Appropriations					
General	26,390	29,049	29,825	30,607	60,432
Statutory Appropriations					
General	2,539	2,000	2,000	2,000	4,000
Total	**28,929**	**31,049**	**31,825**	**32,607**	**64,432**
Expenditures by Category					
Other Operating Expenses	577	0	0	0	0
Payments To Individuals	28,352	30,549	31,325	32,107	63,432
Local Assistance	0	500	500	500	1,000
Total	**28,929**	**31,049**	**31,825**	**32,607**	**64,432**

Activity Description

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

Activity at a Glance

- Provides 27,800 people with disabilities or over age 65 with a monthly cash supplement

Population Served

To receive MSA benefits, a person must be

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

MSA is available to individuals with assets up to $2,000 and couples with assets up to $3,000 and limited income.

Services Provided

The MSA monthly grant standards are $625 each month for individuals living alone and $937 each month for couples. Federal SSI funds pay most of the standards. Although payment amounts vary depending upon a number of factors, MSA monthly grants average about $86 and supplement SSI payments to reach the MSA standards.

Historical Perspective

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

Key Measures

⇒ Percent of SSI adults receiving MSA

More information on Department of Human Services (DHS) measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

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

Contact

For more information on MSA Grants, contact

- Assistant Commissioner Chuck Johnson, (651) 297-4727
- Community Living Supports Director Janel Bush, (651) 282-5205

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	28,955	30,490	30,490	30,490	60,980
Technical Adjustments					
End-of-session Estimate			1,540	2,551	4,091
November Forecast Adjustment		(1,090)	(1,905)	(2,386)	(4,291)
Subtotal - Forecast Base	28,955	29,400	30,125	30,655	60,780
Total	**28,955**	**29,400**	**30,125**	**30,655**	**60,780**
Expenditures by Fund					
Direct Appropriations					
General	28,165	29,400	30,125	30,655	60,780
Statutory Appropriations					
General	696	600	600	600	1,200
Total	**28,861**	**30,000**	**30,725**	**31,255**	**61,980**
Expenditures by Category					
Other Operating Expenses	2	0	0	0	0
Payments To Individuals	28,859	30,000	30,725	31,255	61,980
Total	**28,861**	**30,000**	**30,725**	**31,255**	**61,980**

Activity Description

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

Activity at a Glance

- There are more than 4,900 GRH settings.
- GRH provides room and board for an average of 14,500 recipients a month.
- The basic GRH room and board rate is $692 per month.

Population Served

There are over 4,900 GRH settings serving a monthly average of 14,500 recipients who are unable to live independently in the community due to illness or incapacity.

GRH settings serve a variety of people, including persons with mental retardation, mental illness, chemical dependency, physical disabilities, advanced age, or brain injuries.

People receiving GRH often also receive services through Medical Assistance (MA) Home Care, a home and community-based waiver under Title XIX of the Social Security Act, or mental health grants. In these cases, the GRH rate is restricted to the room and board rate only. The combination of GRH room and board supports and Medical Assistance services enables people to live in the community rather than in a facility.

Services Provided

GRH separately identifies housing costs from services and provides a standard payment rate for housing for aged, blind, and disabled persons in certain congregate settings:

⇒ GRH is a supplement to a client's income to pay for the costs of room and board in specified licensed or registered settings.

⇒ Currently, the basic GRH room and board rate is $692 per month, which is based on a statutory formula. The maximum GRH payment rate for settings that provide services in addition to room and board, such as difficulty of care in adult foster care, is $461.36 per month. In limited cases, and upon county and state approval, GRH will also fund up to $456.75 per month (based on documented costs) for people whose needs require specialized housing arrangements.

⇒ Although GRH is 100% state-funded, these rates are offset by the recipient's own income contribution (usually Supplemental Security Income or Social Security Retirement or Disability Insurance contributions of at least $515.05).

GRH also pays for basic support services, such as oversight and supervision, medication reminders, and appointment arrangement, for people who are ineligible for other service funding mechanisms such as home and community-based waivers or home care.

Historical Perspective

GRH was once part of the Minnesota Supplemental Aid (MSA) Program but was made a separate program in the mid-1990s. There is currently a moratorium on the creation of beds with a rate that exceeds the base rate of $692 unless they are licensed as adult foster care. More recently, all supplemental room and board rates, which are available only for adult foster care settings, are subject to a county average calculated on the basis of FY 2000 data in order to control costs.

Key Measures

⇒ Proportion of public-funded long-term care funds expended in institutional versus community settings

⇒ Number of nursing home residents under age 55 in one year who have become eligible for GRH the subsequent year (under development)

More information on Department of Human Services measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

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

Contact

For more information on Group Residential Housing, contact

- Assistant Commissioner Chuck Johnson, (651) 297-4727Chuck Johnson, (651) 297-4727Chuck Johnson, (651) 297-4727
- Community Living Supports Director Janel Bush, (651) 282-5205

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	94,547	81,055	81,055	81,055	162,110
Technical Adjustments					
End-of-session Estimate			4,179	9,969	14,148
November Forecast Adjustment		6,017	(646)	(914)	(1,560)
Subtotal - Forecast Base	94,547	87,072	84,588	90,110	174,698
Total	**94,547**	**87,072**	**84,588**	**90,110**	**174,698**
Expenditures by Fund					
Direct Appropriations					
General	86,793	87,072	84,588	90,110	174,698
Statutory Appropriations					
General	449	450	450	450	900
Total	**87,242**	**87,522**	**85,038**	**90,560**	**175,598**
Expenditures by Category					
Other Operating Expenses	60	0	0	0	0
Payments To Individuals	87,182	87,522	85,038	90,560	175,598
Total	**87,242**	**87,522**	**85,038**	**90,560**	**175,598**

Activity Description
Refugee Services grants provide federally funded services to help refugees resettle in Minnesota and become self-sufficient.

Population Served
Refugees are people lawfully admitted by the federal government to the United States who are unable to return to their own home because of a well-founded fear of persecution.

Activity at a Glance

Monthly average of refugees receiving resettlement services (prior to 9/01)
- Refugee Cash Assistance 600
- Refugee Medical Assistance 600
- Social Services 400

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

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

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

Historical Perspective
The number of refugees who have been resettled in Minnesota from 1995 to 2004 is estimated at 22,600. The exact number of new arrivals is difficult to verify, because people move between states. Refugees may be from any country; however, refugees from Africa, especially Somalia, have been predominant among recent arrivals.

Prior to September 2001, about 2,300 refugees resettled each year in Minnesota. This represents approximately 4% of the total number of refugees admitted to the United States during the year. The largest group of refugees is from Ethiopia and is joining family members already in Minnesota. After September 2001, resettlement had slowed because of federal restrictions. Recently, numbers of refugees have been returning to pre-September 2001 levels. In addition, approximately 5,000 Hmong refugees from Thailand are expected to resettle in Minnesota during 2004.

Key Measures
⇒ Refugee families are economically self-supporting
- Wage rate at job placement
- 90-day job retention rate

More information on Department of Human Services (DHS) measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding
Refugee Services Grants is funded with appropriations from federal funds.

Contact
For more information on Refugee Services Grants, contact
- Assistant Commissioner Chuck Johnson, (651) 297-4727
- Community Living Supports Director Janel Bush, (651) 282-5205

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Expenditures by Fund					
Statutory Appropriations					
General	1	2	2	2	4
Federal	9,568	11,532	11,531	11,531	23,062
Total	**9,569**	**11,534**	**11,533**	**11,533**	**23,066**
Expenditures by Category					
Other Operating Expenses	290	400	400	400	800
Payments To Individuals	3,904	5,002	5,002	5,002	10,004
Local Assistance	5,375	6,132	6,131	6,131	12,262
Total	**9,569**	**11,534**	**11,533**	**11,533**	**23,066**

Activity Description

Other Children's and Economic Assistance includes food support and food shelves, asset development, housing assistance, Community Action, emergency services, transitional housing, and fraud prevention grants.

Activity at a Glance

- Provides state food assistance to 450 families (1,500 people) each month
- Provides federal food assistance to 63,000 families (110,000 people) each month
- Provides transitional housing to 5,700 people
- Provides assistance to 250,000 households through Community Action Agencies

Population Served

Eligible recipients include

- legal, non-citizens who are not eligible for federal food support and participate in the Minnesota Food Assistance Program (MFAP);
- homeless people and families at risk of homelessness, needing housing and supportive services until they are able to move into stable, permanent housing; and
- economically disadvantaged households, many working and still meeting income eligibility guidelines for program services.

Services Provided

⇒ Supportive Housing/Managed Care is a pilot project in Ramsey and Blue Earth counties that provides integrated employment services, supportive services, housing, and health care for people who are homeless.

⇒ The Transitional Housing Program (THP) provides grants for programs that provide transitional housing and supportive services to homeless people for up to 24 months so that they can find stable, permanent housing.

⇒ Minnesota Community Action Grants provide low-income citizens with the information and skills necessary to become more self-reliant through a statewide network of Community Action Agencies (CAAs). Services are designed locally, based on community assessments, and aimed at ending poverty through high-impact strategies.

⇒ Emergency Services Program (ESP) funds shelters and other agencies to provide emergency shelter, support services, and essential services to homeless persons.

⇒ Food shelves provide food to low-income individuals and families who have exhausted other resources to meet their basic nutrition needs. Food banks, food shelves, on-site meal programs, and shelters provide food through the Minnesota Food Shelf Program (MFSP), The Emergency Food Assistance Program (TEFAP), and Community Food and Nutrition Program (CFNP).

⇒ Family Assets for Independence in Minnesota (FAIM) helps low-income, working Minnesotans build assets via savings accounts and develop positive financial management habits and skills to achieve long-term economic self-sufficiency.

⇒ Food support is provided through Electronic Benefit Transfer (EBT), Food Support Expedited Benefits, and Food Support Cashout Supplemental Security Income (SSI).

⇒ MFAP provides state-funded grants to legal non-citizens who are no longer eligible for federal food support.

⇒ Fraud-prevention grants are awarded to counties to fund early fraud detection and collection efforts.

Historical Perspective

Homeless programs were developed in the 1990s in response to the increasing numbers of children and families experiencing homelessness. The state began funding food assistance because the demand could not be met without state help. Certain legal non-citizens lost eligibility for federal food support in the 1990s. Family Assets for Independence is part of a national asset building initiative that also began in the 1990s. It came from the recognition that low income families are often excluded from financial opportunities for asset development that is available to middle and upper income families.

Key Measures

⇒ Percent of people in poverty who receive food support.
⇒ Number of low-income families participating in FAIM.
⇒ Number of people receiving housing assistance under the Minnesota Transitional Housing Program.
⇒ Number of homeless people receiving shelter through the Emergency Services Program.

More information on Department of Human Services (DHS) measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

Other Children's & Economic Assistance Grants are funded with appropriations from the General Fund and from federal funds.

Contact

For more information on Other Children's & Economic Support Grants–Other Assistance, contact

- Assistant Commissioner, Chuck Johnson, (651) 297-4727
- Transition to Economic Stability Division Acting Director Ann Sessoms, (651) 297-7515
- Community Partnerships Division Director James Huber (651) 284-4120
- Program Assessment and Integrity Division Director Ramona Scarpace (651) 296-5767

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	3,358	3,651	3,651	3,651	7,302
Technical Adjustments					
Current Law Base Change			14	135	149
Transfers Between Agencies			9,116	8,616	17,732
Subtotal - Forecast Base	3,358	3,651	12,781	12,402	25,183
Governor's Recommendations					
Supp Housing Serv for Homeless		0	5,000	5,000	10,000
Total	**3,358**	**3,651**	**17,781**	**17,402**	**35,183**
Expenditures by Fund					
Direct Appropriations					
General	12,422	12,167	17,781	17,402	35,183
Statutory Appropriations					
Special Revenue	1,154	358	300	300	600
Federal	111,944	115,606	114,857	112,902	227,759
Total	**125,520**	**128,131**	**132,938**	**130,604**	**263,542**
Expenditures by Category					
Other Operating Expenses	69	20	13	13	26
Payments To Individuals	101,439	102,669	102,783	102,904	205,687
Local Assistance	24,012	25,442	30,142	27,687	57,829
Total	**125,520**	**128,131**	**132,938**	**130,604**	**263,542**

Program Description

Children and Economic Assistance Management is the administrative support component for Children and Economic Assistance Grants. It is responsible for policy development and program implementation and for managing and operating computer systems support.

Budget Activities Included:

⇒ Children and Economic Assistance Administration

⇒ Children and Economic Assistance Operations

HUMAN SERVICES DEPT

Program: CHILDREN & ECONOMIC ASST MGMT

Program Summary

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	46,468	41,614	41,614	41,614	83,228
Technical Adjustments					
Current Law Base Change			(28)	(28)	(56)
Transfers Between Agencies			706	706	1,412
Subtotal - Forecast Base	46,468	41,614	42,292	42,292	84,584
Governor's Recommendations					
Prevent Homelessness After FC		0	72	66	138
Freeze Max. Child Care Rates		0	0	50	50
Medicare Modernization Act Changes		0	12	0	12
Restructure MHCP Eligibility		0	12	0	12
Total	**46,468**	**41,614**	**42,388**	**42,408**	**84,796**
Health Care Access					
Current Appropriation	1,407	249	249	249	498
Subtotal - Forecast Base	1,407	249	249	249	498
Total	**1,407**	**249**	**249**	**249**	**498**
Federal Tanf					
Current Appropriation	452	452	452	452	904
Subtotal - Forecast Base	452	452	452	452	904
Total	**452**	**452**	**452**	**452**	**904**
Expenditures by Fund					
Direct Appropriations					
General	11,264	11,992	42,388	42,408	84,796
Health Care Access	236	249	249	249	498
Federal Tanf	424	452	452	452	904
Statutory Appropriations					
Special Revenue	64,485	79,575	47,957	48,988	96,945
Federal	9,022	9,139	9,069	9,046	18,115
Total	**85,431**	**101,407**	**100,115**	**101,143**	**201,258**
Expenditures by Category					
Total Compensation	43,871	47,522	45,772	46,012	91,784
Other Operating Expenses	41,560	53,885	54,319	55,081	109,400
Transfers	0	0	24	50	74
Total	**85,431**	**101,407**	**100,115**	**101,143**	**201,258**
Expenditures by Activity					
Children & Econ Assist Admin	17,538	20,960	19,698	19,476	39,174
Children & Econ Assist Ops	67,893	80,447	80,417	81,667	162,084
Total	**85,431**	**101,407**	**100,115**	**101,143**	**201,258**
Full-Time Equivalents (FTE)	**647.0**	**626.9**	**627.9**	**627.9**	

Activity Description

Children's and Economic Assistance Administration provides policy development and administrative support for programs funded through Children's and Economic Assistance Grants.

Activity at a Glance

- Develops children and economic assistance policy for services to more than 500,000 people
- Provides administrative support to child welfare and children's mental health grants
- Works with counties, tribes, and other providers to implement best practices
- Provides training and technical assistance to direct service providers
- Monitors and implements federal actions

Population Served

Services are provided to

- families and individuals who receive cash and food benefits;
- children who receive child support enforcement services;
- children who are at risk of abuse or neglect, in out-of-home placements, in need of adoption, under state guardianship, or have an emotional disturbance and need mental health services; and
- more than 6,600 workers in 87 counties who receive policy, technical support, and training.

Services Provided

Children's and Economic Assistance Administration

- provides technical support and policy interpretation for 87 county human services agencies through training, instructional manuals, policy assistance, and system support help desks;
- assists with case management;
- implements and monitors state-funded grant projects;
- conducts pilot programs to improve service delivery and outcomes;
- implements policy changes and develops and analyzes legislation;
- administers Limited English Proficiency (LEP) services;
- administers social services, cash assistance, and employment services to refugees;
- administers the Adoption Assistance program and reimburses counties for costs related to the Relative Custody Assistance program for children with special needs;
- assures and documents compliance with state and federal laws;
- conducts quality assurance reviews of county practices; and
- manages intergovernmental relations.

Historical Perspective

Staff in Children and Family Services has implemented a number of initiatives in recent years to improve services to families and children.

⇒ The Diversionary Work Program (DWP) was implemented in July 2004. DWP is a four-month program that helps parents immediately go to work rather than go on welfare.

⇒ The Minnesota Family Investment Policy (MFIP) consolidated fund, created by the 2003 legislature, combines funding for a number of family support programs for MFIP participants.

⇒ Alternative response assessment and services are available in all 87 counties to families referred to child protection.

⇒ Mental health screening for children in the child welfare and juvenile justice systems and the expansion of the Children's Therapeutic Services and Supports (CTSS) has been implemented statewide.

⇒ The Children and Community Services Grants, created by the 2003 legislature, consolidates funding for social services for children and families to five counties more flexibility and simplify planning and administrative requirements.

Key Measures

⇒ Current child support collection rate.
⇒ Paternity establishment rate.
⇒ Percentage of young children in quality early childhood care and education settings who are ready for school as measured by an observational performance assessment (under development).
⇒ Percentage of families using child care referral services who report increased ability to seek and select quality child care.
⇒ Adoption: Percent of children who were adopted in fewer that 24 months from the time of latest removal from their homes.
⇒ Recurrence: Percent of children who do not experience repeated neglect or abuse within 12 months of prior report.
⇒ Reentry: Percent of children who entered foster care who did not have a prior out-of-home placement in the previous 12 months.
⇒ Reunification: Percent of children reunified in less than 12 months from the time of the latest removal from their homes.
⇒ Percent of child care assistance leavers who are still employed six months later (under development).
⇒ Percent of people in poverty who receive Food Support.
⇒ MFIP Self-Support Index (percent of adults working 30+ hours or off MFIP cash assistance three years later).
⇒ Percent of adults participating in work activities for specified hours per week.
⇒ Number of moves per calendar year for General Assistance/Group Residential Housing (GRH) adults.
⇒ Percent of SSI adults receiving MSA.
⇒ Proportion of public-funded long-term care funds expended in institutional vs. community settings.
⇒ Number of nursing home residents under age 55 in one year who have become eligible for GRH the subsequent year (under development).
⇒ Refugee families are economically self-supporting
  - ♦ wage rate at job placement; and
  - ♦ 90-day job retention rate.
⇒ Number of low-income families participating in Family Assets for Independence in Minnesota.
⇒ Number of people receiving housing assistance under the Transitional Housing Program.
⇒ Number of homeless people receiving shelter through the Emergency Services Program.

More information on Department of Human Services (DHS) measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

Children's & Economic Assistance Administration is funded primarily with appropriations from the General Fund and from federal funds.

Contact

For more information on Children's & Economic Assistance Administration, contact:

♦ Assistant Commissioner Chuck Johnson, (651) 297-4727

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: CHILDREN & ECONOMIC ASST MGMT
Activity: CHILDREN & ECON ASSIST ADMIN

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	9,674	6,865	6,865	6,865	13,730
Technical Adjustments					
Transfers Between Agencies			706	706	1,412
Subtotal - Forecast Base	9,674	6,865	7,571	7,571	15,142
Governor's Recommendations					
Prevent Homelessness After FC		0	72	66	138
Total	**9,674**	**6,865**	**7,643**	**7,637**	**15,280**
Federal Tanf					
Current Appropriation	452	452	452	452	904
Subtotal - Forecast Base	452	452	452	452	904
Total	**452**	**452**	**452**	**452**	**904**
Expenditures by Fund					
Direct Appropriations					
General	7,153	8,029	7,643	7,637	15,280
Federal Tanf	424	452	452	452	904
Statutory Appropriations					
Special Revenue	939	3,340	2,534	2,341	4,875
Federal	9,022	9,139	9,069	9,046	18,115
Total	**17,538**	**20,960**	**19,698**	**19,476**	**39,174**
Expenditures by Category					
Total Compensation	13,581	14,112	13,540	13,399	26,939
Other Operating Expenses	3,957	6,848	6,158	6,077	12,235
Total	**17,538**	**20,960**	**19,698**	**19,476**	**39,174**
Full-Time Equivalents (FTE)	**213.8**	**195.1**	**196.1**	**196.1**	

Activity Description

Children's and Economic Assistance Operations provides operating and computer systems support for programs funded through Children's and Economic Assistance Grants.

Activity at a Glance

- Provides benefits to more than 500,000 people through MAXIS
- Provides child support services to 400,000 children and parents
- Provides child care assistance to 22,700 families
- Provides data support for services to 25,000 children who are alleged victims of abuse and 18,000 children in out-of-home placements
- Provides system support to more than 6,600 workers in 87 counties

Population Served

Children's & Economic Assistance Operations serves

- Minnesotans who receive economic assistance benefits through MAXIS;
- families who receive child care assistance services through Minnesota Electronic Childcare System (MEC^2), which is part of MAXIS;
- children who receive child support enforcement services through PRISM;
- families and children who receive social services through Social Service Information System (SSIS); and
- more than 3,600 county workers who use MAXIS, PRISM, and MEC^2 and 3,000 county social service workers who use SSIS.

Services Provided

Children's and Economic Assistance Operations supports economic assistance programs by

- operating and maintaining the eligibility and delivery systems for food support, General Assistance (GA), Minnesota Supplemental Aid (MSA), Minnesota Family Investment Program (MFIP), Diversionary Work Program (DWP), Child Care Assistance Program, Medical Assistance (MA), General Assistance Medical Care (GAMC), Group Residential Housing, Minnesota Food Assistance Program, and Emergency General Assistance;
- collecting and distributing child support payments, locating absent parents, establishing paternity, and enforcing of court orders;
- conducting federally mandated quality control reviews, payment accuracy assessment and administrative evaluation for MFIP, food support, MA, child support, and MinnesotaCare;
- administering the Electronic Benefit Transfer (EBT) system;
- managing program integrity (fraud prevention) and control functions;
- collecting and analyzing data trends and activities that determine program effectiveness, establish program error levels to prevent recipient fraud, and support long-range planning; and
- managing claims and recoveries of overpayments for the cash public assistance program, including the Treasury Offset Program (TOP).

In addition, it supports children and family services by

- supporting county social service workers by automating routine tasks, helping determine client needs, and providing timely information on children who have been maltreated, are in out-of-home placement, or who are awaiting adoption;
- managing child protection, out-of-home placement, adoption, and foster care services; and
- supporting chemical dependency, mental health, developmental disability, and elderly programs.

Historical Perspective

Staff in Children and Family Services has implemented a number of initiatives in recent years to improve efficiency and manage for results, including:

⇒ Providing parents access to case information via the internet through Minnesota Child Support On-Line.

⇒ Providing parents who receive child support payments with the option of direct deposit to savings or checking accounts or a stored value card.

⇒ Providing information about affordable housing options through web-based resource.

⇒ Establishing service agreements with each county to define targets for performance.

Key Measures

⇒ Current child support collection rate.
⇒ Paternity establishment rate.
⇒ Percentage of young children in quality early childhood care and education settings who are ready for school as measured by an observational performance assessment (under development).
⇒ Percentage of families using child care referral services who report increased ability to seek and select quality child care.
⇒ Adoption: Percent of children who were adopted in fewer that 24 months from the time of latest removal from their homes.
⇒ Recurrence: Percent of children who do not experience repeated neglect or abuse within 12 months of prior report.
⇒ Reentry: Percent of children who entered foster care who did not have a prior out-of-home placement in the previous 12 months.
⇒ Reunification: Percent of children reunified in less than 12 months from the time of the latest removal from their homes.
⇒ Percent of child care assistance leavers who are still employed six months later (under development).
⇒ Percent of people in poverty who receive Food Support.
⇒ MFIP Self-Support Index (percent of adults working 30+ hours or off MFIP cash assistance three years later).
⇒ Percent of adults participating in work activities for specified hours per week.
⇒ Number of moves per calendar year for General Assistance/Group Residential Housing (GRH) adults.
⇒ Percent of SSI adults receiving MSA.
⇒ Proportion of public-funded long-term care funds expended in institutional vs. community settings.
⇒ Number of nursing home residents under age 55 in one year who have become eligible for GRH the subsequent year (under development).
⇒ Refugee families are economically self-supporting:
  - ♦ wage rate at job placement; and
  - ♦ 90-day job retention rate.
⇒ Number of low-income families participating in Family Assets for Independence in Minnesota.
⇒ Number of people receiving housing assistance under the Transitional Housing Program.
⇒ Number of homeless people receiving shelter through the Emergency Services Program.

More information on Department of Human Services (DHS) measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

Children's and Economic Assistance Operations is funded with appropriations from the General Fund and Health Care Access Fund and from federal funds.

Contact

For more information on Children's and Economic Assistance Operations, contact

- ♦ Assistant Commissioner Chuck Johnson, (651) 297-4727
- ♦ Child Support Enforcement Division Director Wayland Campbell, (651) 297-8232
- ♦ Transition Support Systems Division Director Kate Wulf, (651) 297-1428
- ♦ SSIS Division Director Gwen Wildermuth, (651) 772-3780
- ♦ Program Assessment & Integrity Division Director Ramona Scarpace, (651) 296-5767

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: CHILDREN & ECONOMIC ASST MGMT
Activity: CHILDREN & ECON ASSIST OPS

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	36,794	34,749	34,749	34,749	69,498
Technical Adjustments					
Current Law Base Change			(28)	(28)	(56)
Subtotal - Forecast Base	36,794	34,749	34,721	34,721	69,442
Governor's Recommendations					
Freeze Max. Child Care Rates		0	0	50	50
Medicare Modernization Act Changes		0	12	0	12
Restructure MHCP Eligibility		0	12	0	12
Total	**36,794**	**34,749**	**34,745**	**34,771**	**69,516**
Health Care Access					
Current Appropriation	1,407	249	249	249	498
Subtotal - Forecast Base	1,407	249	249	249	498
Total	**1,407**	**249**	**249**	**249**	**498**
Expenditures by Fund					
Direct Appropriations					
General	4,111	3,963	34,745	34,771	69,516
Health Care Access	236	249	249	249	498
Statutory Appropriations					
Special Revenue	63,546	76,235	45,423	46,647	92,070
Total	**67,893**	**80,447**	**80,417**	**81,667**	**162,084**
Expenditures by Category					
Total Compensation	30,290	33,410	32,232	32,613	64,845
Other Operating Expenses	37,603	47,037	48,161	49,004	97,165
Transfers	0	0	24	50	74
Total	**67,893**	**80,447**	**80,417**	**81,667**	**162,084**
Full-Time Equivalents (FTE)	**433.2**	**431.8**	**431.8**	**431.8**	

Program Description

Health Care Grants purchase preventive and primary health care services, such as physician services, medications, and dental care for low-income families with children, elderly, and people with disabilities. More than 660,000 Minnesotans receive health care assistance through this grant area each year.

Federal Medicaid is the largest single source of federal funding in the Minnesota budget and supports activity throughout the Department of Human Services (DHS) budget. Within the Health Care Grants program area, federal Medicaid funding supports MinnesotaCare Grants, Medical Assistance (MA) Basic Health Care Grants-Families and Children, and MA Basic Health Care Grants-Elderly and Disabled. Within the Continuing Care Grants program area, federal Medicaid funding supports MA Long-Term Care Waivers and Home Care Grants and MA Long-Term Care Facilities Grants.

Budget Activities Included:

⇒ MinnesotaCare Grants
⇒ MA Basic Health Care Grants – Families and Children
⇒ MA Basic Health Care Grants – Elderly and Disabled
⇒ General Assistance Medical Care Grants
⇒ Prescription Drug Program
⇒ Other Health Care Grants

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	1,288,084	1,473,626	1,473,626	1,473,626	2,947,252
Technical Adjustments					
Current Law Base Change			4,345	7,300	11,645
End-of-session Estimate			169,502	333,695	503,197
November Forecast Adjustment		(26,506)	124,150	244,721	368,871
Program/agency Sunset			(694)	(694)	(1,388)
Subtotal - Forecast Base	1,288,084	1,447,120	1,770,929	2,058,648	3,829,577
Governor's Recommendations					
Medicare Modernization Act Changes		0	(6,973)	(13,810)	(20,783)
Pharmaceutical Purchasing		0	(7,976)	(6,141)	(14,117)
Hospital Rate Reduction		0	(16,076)	(35,978)	(52,054)
Restructure MHCP Eligibility		0	51,365	43,840	95,205
Better Manage Health Care Costs		0	(1,811)	(3,820)	(5,631)
Refinance Health Care Programs		0	(259,823)	(420,338)	(680,161)
Improve Mental Health Coverage		0	131	3,150	3,281
Total	**1,288,084**	**1,447,120**	**1,529,766**	**1,625,551**	**3,155,317**
Health Care Access					
Current Appropriation	254,120	282,689	282,689	282,689	565,378
Technical Adjustments					
End-of-session Estimate			64,706	97,884	162,590
November Forecast Adjustment		(44,531)	(61,132)	(164,336)	(225,468)
Subtotal - Forecast Base	254,120	238,158	286,263	216,237	502,500
Governor's Recommendations					
Hospital Rate Reduction		0	(1,312)	(2,430)	(3,742)
Restructure MHCP Eligibility		0	(79,225)	(97,331)	(176,556)
Better Manage Health Care Costs		0	(33)	(57)	(90)
Refinance Health Care Programs		0	259,823	420,338	680,161
Total	**254,120**	**238,158**	**465,516**	**536,757**	**1,002,273**
Expenditures by Fund					
Direct Appropriations					
General	1,374,947	1,437,387	1,529,766	1,625,551	3,155,317
Health Care Access	295,495	237,408	465,516	536,757	1,002,273
Statutory Appropriations					
General	0	25,097	23,904	23,821	47,725
Health Care Access	0	27,992	26,491	31,386	57,877
Special Revenue	621	2,869	2,050	2,050	4,100
Federal	1,597,810	1,558,226	1,680,106	1,776,238	3,456,344
Total	**3,268,873**	**3,288,979**	**3,727,833**	**3,995,803**	**7,723,636**
Expenditures by Category					
Other Operating Expenses	205	365	365	365	730
Payments To Individuals	3,267,454	3,277,113	3,713,257	3,980,463	7,693,720
Local Assistance	1,214	11,501	14,211	14,975	29,186
Total	**3,268,873**	**3,288,979**	**3,727,833**	**3,995,803**	**7,723,636**

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Expenditures by Activity					
Minnesotacare Gr	487,003	431,459	403,488	279,483	682,971
Ma Basic Health Care - F&C Gr	1,226,671	1,188,594	1,426,006	1,713,633	3,139,639
Ma Basic Health Care - E&D Gr	1,299,644	1,410,309	1,539,609	1,575,740	3,115,349
General Asst Medical Care Gr	245,624	243,515	348,393	420,338	768,731
Prescription Drug Program Gr	8,507	9,996	4,248	20	4,268
Other Health Care Gr	1,424	5,106	6,089	6,589	12,678
Total	**3,268,873**	**3,288,979**	**3,727,833**	**3,995,803**	**7,723,636**

Activity Description

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

Activity at a Glance

- Purchases health care for approximately 150,000 enrollees
- Assists low-income, working families and adults who cannot afford health insurance
- Invests in preventive health care that makes Minnesota one of the healthiest states in the country
- Supports families transitioning from welfare to work

Population Served

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

⇒ Children, parents with children under 21, and pregnant women must have household incomes at or below 275% of the federal poverty guidelines (FPG). In FY 2004, an average of 116,000 people were enrolled in these categories.

⇒ Adults (over 21) without children must have household incomes at or below 175% FPG; however, those with income greater than 75% FPG but no greater than 175% FPG are entitled to a limited benefit set. In FY 2004, an average of 34,000 people were enrolled in this category (20,000 people in the MinnesotaCare Limited Benefit set and 14,000 people with incomes under 75% FPG).

⇒ Except for certain low-income children, applicants are not eligible if they have other health insurance (including Medicare), have access to coverage through their employer and the employer's share of the premium is 50% or more, or have had other insurance within the past four months.

Income as a percent of federal poverty guidelines (FPG)	Approximate percent of MinnesotaCare households May 2004
≤ 100	42.0%
101% - 150%	31.5%
151% - 175%	12.4%
176% - 200%	5.9%
201% - 275%	7.7%
>275%	0.5%

The average enrollee premium for FY 2003 was $23 per person per month. The premium for some low-income children is as little as $4 per month.

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

Services Provided

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

- medical transportation (emergency use only for non-pregnant adults);
- chemical dependency treatment;
- chiropractic care;
- doctor and health clinic visits;
- dental services - $500 annual cap for non-pregnant adults;
- emergency room services;
- eye checkups and prescription eyeglasses (some restrictions apply) - $25 co-pay on eyeglasses for non-pregnant adults;
- home care such as a nurse visit or home health aide;
- hospice care;

- immunizations;
- laboratory and X-ray services;
- medical equipment and supplies;
- mental health services;
- most prescription drugs - $3 co-pay for non-pregnant adults;
- rehabilitative therapy; and
- hospitalization
  - ⇒ no dollar limit for children under 21 and pregnant women;
  - ⇒ no dollar limit for adults who have a child under 21 in their home whose income is equal to or less than 175% FPG; and
  - ⇒ all other adults have a $10,000 limit per year – 10% co-pay (up to $1,0000 co-pay).

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

Adults without children between 75% and 175% of FPG have coverage with a benefit set limited to
- up to $10,000 per year in patient services - 10% co-pay (up to $1,0000 co-pay);
- up to $10,000 per year for chemical dependency residential treatment; and
- up to $5,000 per calendar year for
  - ⇒ physician - $5 co-pay on non-preventive services;
  - ⇒ chiropractic;
  - ⇒ lab, x-ray;
  - ⇒ outpatient hospital - $50 ER co-pay;
  - ⇒ ambulatory surgical center; and
  - ⇒ prescription drugs - $3 co-pay, $20/month maximum.

Historical Perspective

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

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

In 1995, the federal government approved an amendment to the Prepaid Medical Assistance Program M.S.115 Waiver (known as PMAP+ or Phase I of the MinnesotaCare Health Care Reform Waiver) allowing for the provision of federal Medicaid matching funds for children and pregnant women in MinnesotaCare with income at or below 275% of FPG. This was followed by an amendment approved in 1999 that allows federal Medicaid matching funds for MinnesotaCare parents and caretakers with incomes up to 275% of FPG. PMAP+ waiver provisions also allow for different cost sharing and benefits for parents and caretakers in MinnesotaCare than in MA. The PMAP+ waiver expires 6-30-05.

A three-year extension request will be submitted to the federal government in December 2004. While federal managed care regulations now make it possible to serve most populations through a managed care delivery system under the Medicaid State Plan without the waiver, the regulations do not include provisions for the expansion of Medicaid coverage to the MinnesotaCare children, pregnant women, and parent and caretaker expansion groups and limit cost sharing and premium structures to those allowed under MA. The M.S 1115 waiver extension will seek continued authority for the MinnesotaCare expansion. Denial would result in the loss of federal matching funds for MinnesotaCare expansion populations.

The MinnesotaCare program received a boost in FY 2002 after the federal government agreed to give Minnesota access to its federal State Children's Health Insurance Program (S-CHIP) funds, a program created by Congress in 1997 to help states cover more low-income children. Minnesota had been unable to receive S-CHIP funding because MinnesotaCare provided health care coverage to low-income families and children prior to the enactment of S-CHIP. Beginning in FY 2002, the state receives federal funding based on state spending for parents in MinnesotaCare.

In 2003, benefits for MinnesotaCare adults without children with income over 75% of FPG but no greater than 175% of FPG were limited to certain core services and capped at $5,000 per year.

Key Measures

⇒ Cost increases in Minnesota health care programs.

⇒ For children enrolled in Minnesota health care programs, percent who receive the expected number of well-child visits.

More information on Department of Human Services (DHS) measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

MinnesotaCare Grants is funded with appropriations from the Health Care Access Fund, from federal funds, and from enrollee premiums.

Contact

For more information on MinnesotaCare Grants, contact

- Assistant Commissioner for Health Care Brian Osberg, (651) 284-4388
- Health Care Eligibility and Access Director Kathleen Henry, (651) 296-8818

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: HEALTH CARE GRANTS
Activity: MINNESOTACARE GR

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
Health Care Access					
Current Appropriation	253,370	281,939	281,939	281,939	563,878
Technical Adjustments					
End-of-session Estimate			64,706	97,884	162,590
November Forecast Adjustment		(44,531)	(61,132)	(164,336)	(225,468)
Subtotal - Forecast Base	253,370	237,408	285,513	215,487	501,000
Governor's Recommendations					
Hospital Rate Reduction		0	(1,312)	(2,430)	(3,742)
Restructure MHCP Eligibility		0	(79,225)	(97,331)	(176,556)
Better Manage Health Care Costs		0	(33)	(57)	(90)
Total	**253,370**	**237,408**	**204,943**	**115,669**	**320,612**
Expenditures by Fund					
Direct Appropriations					
Health Care Access	295,383	237,408	204,943	115,669	320,612
Statutory Appropriations					
Health Care Access	0	27,992	26,491	31,386	57,877
Federal	191,620	166,059	172,054	132,428	304,482
Total	**487,003**	**431,459**	**403,488**	**279,483**	**682,971**
Expenditures by Category					
Payments To Individuals	487,003	431,459	403,488	279,483	682,971
Total	**487,003**	**431,459**	**403,488**	**279,483**	**682,971**

Activity Description

Medical Assistance (MA) Basic Health Care Grants–Families and Children purchase health care services for the poorest Minnesotans. It is distinguished from MinnesotaCare in a number of ways – its income guidelines are lower, it does not have premiums, and it pays retroactively for medical bills incurred.

Activity at a Glance

- Purchases preventive and primary health care for 320,000 people (FY 2004 monthly average), making it the state's largest publicly funded health care program
- Acts as a safety net health care program for the lowest income Minnesotans

Population Served

Local county agencies determine eligibility for MA within federal and state guidelines. MA Basic Health Care Grants–Families and Children serve

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

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

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

Enrollees who become ineligible for MA because of increased earned income or child/spousal maintenance may be eligible for transitional MA for four to 12 months.

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

Services Provided

The department purchases most services for this population through capitated rate contracts with health plans. In most areas of the state, MA parents and children have multiple health plans from which to choose.

MA basic health care services include

- physician services - $3 co-pay on non-preventive services;
- ambulance and emergency room services - $6 co-pay on non-emergency ER visits;
- lab and X-ray;
- rural health clinics;
- chiropractic services - $3 co-pay;
- early periodic screening, diagnosis, and treatment;
- mental health, alcohol, and drug treatment;
- inpatient and outpatient hospital care;
- eyeglasses and eye care - $3 co-pay on eyeglasses;
- immunizations;
- medical transportation, supplies and equipment;
- prescription medications - $3 co-pay on brand names, $1 co-pay on generic - $20 per month maximum;
- dental care - $500 annual dental cap for non-pregnant adults;
- hospice; and
- rehabilitative therapies.

The following people do not have to pay co-pays: pregnant women, children under age 21, people residing in or expecting to reside for more than 30 days in a nursing home or other long-term care facility, people receiving hospice care, and people in the Refugee Medical Assistance Program.

Historical Perspective

In 1966—less than a year after Congress established the Medicaid program under Title XIX of the Social Security Act—Minnesota began receiving federal matching funds for the state's Medical Assistance program. In 1998, federal matching funds were appropriated by Congress for the State-Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act. In 1999, Minnesota began receiving SCHIP funds for coverage provided to some low-income children enrolled in Medical Assistance and later for other health care expenditures as well.

By accepting 50% federal matching funds, states are subject to federal regulations concerning program administration, but have certain options concerning coverage of groups and services and provider reimbursement rates.

With changes to federal Medicaid requirements, Minnesota's Medical Assistance program has expanded since the mid-1980s. The expansions have focused primarily on low-income, uninsured, or under-insured children, as well as eligibility changes to better support seniors and people with disabilities in their own home or in small, community-based settings. In 2002, the income limit for children was increased for children ages two through 18 to 170% of the federal poverty guideline. This standard was reduced in 2004 to 150% of FPG.

Minnesota's investments in access to health care, such as those in Medical Assistance, are one reason that the United Health Foundation, a group of leading public health scholars, ranked Minnesota in a tie for first place with Vermont as the healthiest states in 2003.

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

Key Measures

⇒ Cost increase in Minnesota health care programs.

⇒ For children enrolled in Minnesota health care programs, percent who receive the expected number of well-child visits.

More information on Department of Human Services (DHS) measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

MA Basic Health Care Grants–Families and Children is funded with appropriations from the General Fund and federal Medicaid funds.

Contact

For more information about MA Basic Health Care Grants–Families and Children, contact

- Assistant Commissioner for Health Care Brian Osberg, (651) 284-4388
- Health Care Eligibility and Access Director Kathleen Henry, (651) 296-8818
- State Medicaid Director Christine Bronson, (651) 296-4332

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT

Program: HEALTH CARE GRANTS

Activity: MA BASIC HEALTH CARE - F&C GR

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	427,769	489,545	489,545	489,545	979,090
Technical Adjustments					
End-of-session Estimate			77,596	176,325	253,921
November Forecast Adjustment		(10,102)	82,546	124,123	206,669
Subtotal - Forecast Base	427,769	479,443	649,687	789,993	1,439,680
Governor's Recommendations					
Pharmaceutical Purchasing		0	(951)	(1,126)	(2,077)
Hospital Rate Reduction		0	(6,860)	(18,230)	(25,090)
Restructure MHCP Eligibility		0	(9,966)	(11,638)	(21,604)
Better Manage Health Care Costs		0	(478)	(626)	(1,104)
Improve Mental Health Coverage		0	33	2,760	2,793
Total	**427,769**	**479,443**	**631,465**	**761,133**	**1,392,598**
Expenditures by Fund					
Direct Appropriations					
General	512,908	479,443	631,465	761,133	1,392,598
Statutory Appropriations					
General	0	17,967	17,371	17,329	34,700
Federal	713,763	691,184	777,170	935,171	1,712,341
Total	**1,226,671**	**1,188,594**	**1,426,006**	**1,713,633**	**3,139,639**
Expenditures by Category					
Payments To Individuals	1,226,671	1,180,370	1,417,219	1,704,582	3,121,801
Local Assistance	0	8,224	8,787	9,051	17,838
Total	**1,226,671**	**1,188,594**	**1,426,006**	**1,713,633**	**3,139,639**

Activity Description

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

Activity at a Glance

- Purchases health care for approximately 52,000 elderly Minnesotans and 90,000 people with disabilities (FY 2004 monthly average)
- Helps 7,200 elderly and 1,900 people with disabilities pay Medicare premiums and co-payments (FY 2004 monthly average)

Population Served

Local county agencies determine eligibility for MA within federal and state guidelines. Minnesotans eligible for full MA coverage include

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

The asset limit is $3,000 for a single person and $6,000 for a couple. Some assets like homestead property and burial funds are not counted.

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

Additionally, several thousand Minnesotans receive help paying Medicare costs only, rather than comprehensive MA coverage. For Medicare enrollees with income at or below 100% of the FPG, MA covers all Medicare cost-sharing including premiums. For Medicare enrollees with income between 100% and 120% FPG, MA covers the Medicare Part B premium. Medicare enrollees with income between 120% and 135% FPG receive coverage of the Part B premium only through 9-30-04. Higher asset limits apply to these enrollees: $10,000 for a single person and $18,000 for a couple.

About 6,000 MA enrollees with disabilities receive full MA coverage under Medical Assistance for Employed Persons with Disabilities (MA-EPD). To be eligible for MA-EPD, an individual must

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

Since January 2004, all MA-EPD eligible people pay premiums. In calendar year 2003, premiums averaged $40 to $45 per month. A majority of enrollees had earned gross income of less than $800 per month.

Services Provided

Department of Human Services (DHS) purchases services for people with disabilities and some elderly. MA basic health care services include

- physician services - $3 co-pay on non-preventive services;
- ambulance and emergency room services - $6 co-pay on non-emergency ER visits;
- lab and X-ray;
- rural health clinics;
- chiropractic services - $3 co-pay;
- early periodic screening, diagnosis, and treatment;

- mental health, alcohol, and drug treatment;
- inpatient and outpatient hospital care;
- eyeglasses and eye care - $3 co-pay on eyeglassses;
- immunizations;
- medical supplies and equipment;
- prescription medications - $3 brand name co-pay, $1 generic co-pay - $20 per month maximum;
- dental care - $500 dental cap for non-pregnant adults;
- medical transportation;
- rehabilitative therapies; and
- hospice.

The following people do not have to pay co-pays: people residing in or expecting to reside for more than 30 days in a nursing home or other long-term care facility, people receiving hospice care, and people in the Refugee Medical Assistance Program.

MA coverage of long-term care services, such as nursing home and home care services, are funded through the Continuing Care portion of the department's budget.

Historical Perspective

Medical Assistance has long served as a health care safety net for people with disabilities and elderly residents who have low income or have medical expenses that can be used to reduce income to the income limit. For many, MA acts as a supplement to Medicare, helping low-income Medicare enrollees pay premiums and co-payments.

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

Prior to 2001, the income limits for most MA elderly and disabled were about 69% of the FPG.

In July 1999, Minnesota added Medical Assistance for Employed Persons with Disabilities (MA-EPD) to allow people with disabilities to earn income and still qualify for, or buy into, MA. Enrollment in the program leveled off in 2002, with about 6,220 people as of March 2004. Nearly 93% of enrollees have Medicare as their primary health care coverage, while MA-EPD covers additional services such as prescription drugs and personal care services.

Minnesota's investments in access to health care, such as those in Medical Assistance, are one reason that the United Health Foundation, a group of leading public health scholars, ranked Minnesota in a tie for first place with Vermont as the healthiest states in 2003.

Since the 1970s, Minnesota's approach to purchasing basic health care benefits for seniors enrolled in Medical Assistance has evolved from strictly fee-for-service to increased use of more contracts with health plans to deliver care for a fixed or "capitated" amount per person. Purchasing with capitated contracts provides more incentive for cost-effective and coordinated care and access to the same health care providers as the general public.

In 2003, Congress passed the Medicare Prescription Drug, Improvement and Modernization Act of 2003. It marks the biggest change to the Medicare Program in nearly 40 years. The Act provides seniors and people living with disabilities a prescription drug benefit, more choices and better benefits under Medicare.

Key Measures

⇒ Cost increases in Minnesota health care programs.
⇒ Inpatient hospital average monthly cost per enrollee.
⇒ Pharmacy average monthly cost per enrollee.
⇒ Special transportation average monthly cost per enrollee.

More information on Department of Human Services measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

MA Basic Health Care Grants–Elderly and Disabled is funded with appropriations from the General Fund and from federal funds.

Contact

For more information about MA Basic Health Care Grants–Elderly and Disabled, contact

- Assistant Commissioner for Health Care Brian Osberg, (651) 284-4388
- Health Care Eligibility and Access Director Kathleen Henry, (651) 296-8818
- Health Care Purchasing Director James Chase, (651) 215-0125
- State Medicaid Director Christine Bronson, (651) 296-4332

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: HEALTH CARE GRANTS
Activity: MA BASIC HEALTH CARE - E&D GR

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	610,518	743,858	743,858	743,858	1,487,716
Technical Adjustments					
End-of-session Estimate			76,447	122,982	199,429
November Forecast Adjustment		(30,337)	(6,870)	5,651	(1,219)
Subtotal - Forecast Base	610,518	713,521	813,435	872,491	1,685,926
Governor's Recommendations					
Pharmaceutical Purchasing		0	(6,483)	(4,596)	(11,079)
Hospital Rate Reduction		0	(5,025)	(8,394)	(13,419)
Restructure MHCP Eligibility		0	2,158	4,422	6,580
Better Manage Health Care Costs		0	(1,239)	(2,954)	(4,193)
Improve Mental Health Coverage		0	98	390	488
Total	**610,518**	**713,521**	**802,944**	**861,359**	**1,664,303**
Expenditures by Fund					
Direct Appropriations					
General	607,591	702,946	802,944	861,359	1,664,303
Statutory Appropriations					
General	0	7,110	6,513	6,472	12,985
Federal	692,053	700,253	730,152	707,909	1,438,061
Total	**1,299,644**	**1,410,309**	**1,539,609**	**1,575,740**	**3,115,349**
Expenditures by Category					
Payments To Individuals	1,299,644	1,410,309	1,539,609	1,575,740	3,115,349
Total	**1,299,644**	**1,410,309**	**1,539,609**	**1,575,740**	**3,115,349**

Activity Description

General Assistance Medical Care (GAMC) Grants pay for medical care for low-income Minnesotans who are ineligible for Medical Assistance (MA) or other state or federal health care programs–-primarily low-income adults between the ages of 21 and 64 who do not have dependent children.

Activity at a Glance

- Pays for preventive and primary health care for approximately 35,000 Minnesotans not eligible for either MinnesotaCare or Medical Assistance (FY 2004 monthly average)
- Serves primarily low-income adults without children

Population Served

Local county agencies determine eligibility for GAMC within state guidelines. GAMC serves

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

Eligibility criteria include

- household income may not exceed 75% of the federal poverty guidelines (FPG), except that people with incomes between 75% and 175% of the FPG may qualify for inpatient hospitalization costs and physicians' services incurred during the hospitalization; and
- assets may not exceed $1,000 per household for full coverage, although some assets like homestead property and burial funds are not counted. For hospital only coverage, assets may not exceed $10,000 for a household of one and $20,000 for a household of two or more.

Coverage is available for medical bills incurred no earlier than the date of application.

Services Provided

Department of Human Services (DHS) purchases services for over half of this population through capitated rate contracts with health plans.

Services provided under GAMC include

- inpatient and outpatient hospital care;
- drugs and medical supplies - $3 brand name co-pay, $1 generic co-pay;
- physician services - $3 co-pay for non-preventive services;
- immunizations;
- hearing aids;
- alcohol and drug treatment;
- medical equipment and supplies;
- prosthetics;
- emergency-room services - $25 co-pay on non-emergency ER visits;
- dental care - $500 dental cap;
- chiropractic services - $3 co-pay;
- medical transportation - emergency only;
- eye exams and eyeglasses - $25 co-pay on eyeglasses; and
- public health nursing services.

The hospital-only (GHO) program covers

- inpatient hospital services;
- physicians' services received during the inpatient hospitalization; and
- services of a certified registered nurse anesthetist (CRNA) for hospitals that have elected not to include these charges in the inpatient daily rate.

Historical Perspective

The legislature established the state-funded GAMC program in 1976.

GAMC paid for the same broad range of medical services as MA until 1981. In 1981, coverage was restricted to seven major services: inpatient hospital care, outpatient hospital care, prescription drugs, physician services, medical transportation, dental care, and community mental health center day treatment. Since then, many services have been added back into coverage.

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

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

In 2003, the following eligibility provisions were eliminated

- coverage for people with incomes over 75% of the FPG who incurred medical bills exceeding the difference between their income and this limit. This provision, known as spenddown, was replaced with the hospital-only option up to the 175% of FPG income cap;
- coverage for bills incurred before the date of application. Coverage was previously available for bills incurred in the month before the application; and
- coverage for other undocumented and non-immigrant people with medical emergencies and for non-state residents who incurred costs because of an accident in Minnesota. These groups were previously covered through the Emergency GAMC program.

Key Measures

⇒ Cost increases in Minnesota health care programs.
⇒ Inpatient hospital average monthly cost per enrollee.
⇒ Pharmacy average monthly cost per enrollee.

More information on Department of Human Services (DHS) measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

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

Contact

For more information on General Assistance Medical Care Grants, contact

- Assistant Commissioner for Health Care Brian Osberg, (651) 284-4388
- Health Care Eligibility and Access Director Kathleen Henry, (651) 296-8818

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: HEALTH CARE GRANTS
Activity: GENERAL ASST MEDICAL CARE GR

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	239,861	229,960	229,960	229,960	459,920
Technical Adjustments					
End-of-session Estimate			15,459	34,388	49,847
November Forecast Adjustment		13,933	48,474	114,947	163,421
Subtotal - Forecast Base	239,861	243,893	293,893	379,295	673,188
Governor's Recommendations					
Pharmaceutical Purchasing		0	(388)	(419)	(807)
Hospital Rate Reduction		0	(4,191)	(9,354)	(13,545)
Restructure MHCP Eligibility		0	59,173	51,056	110,229
Better Manage Health Care Costs		0	(94)	(240)	(334)
Health Care Program Refinancing		0	(259,823)	(420,338)	(680,161)
Total	**239,861**	**243,893**	**88,570**	**0**	**88,570**
Health Care Access					
Current Appropriation	0	0	0	0	0
Subtotal - Forecast Base	0	0	0	0	0
Governor's Recommendations					
Health Care Program Refinancing		0	259,823	420,338	680,161
Total	**0**	**0**	**259,823**	**420,338**	**680,161**
Expenditures by Fund					
Direct Appropriations					
General	245,624	243,515	88,570	0	88,570
Health Care Access	0	0	259,823	420,338	680,161
Total	**245,624**	**243,515**	**348,393**	**420,338**	**768,731**
Expenditures by Category					
Payments To Individuals	245,624	243,515	348,393	420,338	768,731
Total	**245,624**	**243,515**	**348,393**	**420,338**	**768,731**

Activity Description

The Prescription Drug Program (PDP) pays for medications for Medicare beneficiaries who do not otherwise have prescription drug coverage and cannot obtain the medication through a manufacturer's free drug program. The program is state funded and rebates received from drug manufacturers help reduce costs. PDP is not an entitlement. Assistance is provided as long as program costs do not exceed appropriated funds and rebate proceeds.

Activity at a Glance

- Pays for prescription drugs for Medicare beneficiaries who do not qualify for Medical Assistance and have incomes at or below 120% of the federal poverty guidelines
- Assists approximately 7,300 people a month (FY 2004 monthly average)

Population Served

Elderly and disabled Medicare beneficiaries, who have income at or below 120% of the federal poverty guideline (FPG) by family size and do not qualify for Medical Assistance (MA) without a spend-down, may be eligible for the PDP. PDP enrollees must be Minnesota residents for at least six months and not have had prescription drug coverage within four months of applying.

The asset limit is $10,000 for a single person and $18,000 for a family of two or more. Some assets like homestead property and burial funds are not counted.

Services Provided

PDP pays for most prescription drugs after enrollees pay the first $35 per month (per person).

Historical Perspective

Originally called the Senior Drug Program (SDP), the program started on 1-1-99, covering Medicare beneficiaries age 65 and older whose income did not exceed 120% of the FPG. The asset limit was $4,000 for a single person and $6,000 for a family of two or more. Enrollees were required to pay an annual enrollment fee of $120 and a monthly deductible of $25 (per person). Drugs covered in the SDP were the same as those covered in the MA program.

Effective 7-1-99, the annual enrollment fee was eliminated and the monthly deductible was increased to $35. At the same time, coverage was limited to those drugs covered by a rebate contract between the state and drug companies.

On 7-1-2000, the name of the program was changed to the PDP. Starting 10-1-2000, the asset limit for the program increased to $10,000 for a single person and $18,000 for a family of two or more. On 7-1-02, the program expanded to cover Medicare beneficiaries, under age 65 who have disabilities and incomes at or below 120% of the FPG.

Since October 2003, all Prescription Drug Program applicants and enrollees must be referred to RxConnect™, a service of the Minnesota Board on Aging, to determine if their PDP-eligible prescriptions can be covered by drug manufacturers' patient assistance programs. In December 2003, the Medicare Prescription Drug, Improvement and Modernization Act was created. The new law provides a prescription drug benefit to Medicare beneficiaries, many of whom are currently enrolled in the Prescription Drug Program. As a result, demand for the Prescription Drug Program will likely be affected in the future.

Key Measures

⇒ Pharmacy average monthly cost per enrollee

More information on Department of Human Services (DHS) measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

The PDP is funded with appropriations from the General Fund; costs are reduced by negotiated rebates from drug manufacturers.

Contact

For more information about the Prescription Drug Program, contact

- Assistant Commissioner for Health Care Brian Osberg, (651) 284-4388
- Health Care Eligibility and Access Director Kathleen Henry, (651) 296-8818

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT

Program: HEALTH CARE GRANTS

Activity: PRESCRIPTION DRUG PROGRAM GR

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	9,239	9,226	9,226	9,226	18,452
Technical Adjustments					
Current Law Base Change			2,129	4,584	6,713
Subtotal - Forecast Base	9,239	9,226	11,355	13,810	25,165
Governor's Recommendations					
Medicare Modernization Act Changes		0	(6,973)	(13,810)	(20,783)
Pharmaceutical Purchasing		0	(154)	0	(154)
Total	**9,239**	**9,226**	**4,228**	**0**	**4,228**
Expenditures by Fund					
Direct Appropriations					
General	8,507	9,976	4,228	0	4,228
Statutory Appropriations					
General	0	20	20	20	40
Total	**8,507**	**9,996**	**4,248**	**20**	**4,268**
Expenditures by Category					
Payments To Individuals	8,507	9,996	4,248	20	4,268
Total	**8,507**	**9,996**	**4,248**	**20**	**4,268**

Activity Description

Other Health Care Grants contains two elements:

⇒ County Prepaid Medical Assistance (PMAP) grants defray the administrative costs of both educating Medical Assistance (MA) and General Assistance Medical Care (GAMC) enrollees about PMAP and enrolling them with a health plan.

⇒ Minnesota Health Care Program Outreach reduces the number of uninsured Minnesotans by educating people about the importance of having health insurance coverage and how to access preventive health care and assisting eligible people enroll in Minnesota's publicly funded health care programs.

Activity at a Glance

- Provides county PMAP grants of about $150,000 per year to reduce county costs for administering prepaid health care.
- Since 1997, has funded outreach to over 40,000 people who have been enrolled in a health care program by agencies funded with outreach grants

Population Served

MA and GAMC enrollees in 82 Minnesota counties participate in PMAP. These grants fund shared services that reduce county costs to educate and enroll people in prepaid health care.

Minnesota Health Care Program Outreach grants are targeted toward reaching people eligible for, but not enrolled, in MA, GAMC, or MinnesotaCare.

Services Provided

County PMAP grants defray the cost of PMAP administration including

- education;
- advocacy; and
- outreach for county residents.

Minnesota Health Care Programs Outreach grants

- educate people about the importance of having and maintaining health insurance coverage;
- assist Minnesotans in enrolling in publicly funded health care programs;
- provide ongoing support to keep people and families enrolled; and
- educate uninsured people and families on accessing preventive health care.

Historical Perspective

Minnesota Health Care Program Grants were first approved by the legislature for FY 1998 in an effort to reach the remaining uninsured. Approximately $5.5 million has been spent on grant awards targeted toward uninsured populations and particular populations.

Many of the uninsured in Minnesota have historically been difficult to reach for reasons including

- they live in unstable or complicated situations;
- their lifestyle is chaotic which undermines reasonable decision making and follow-through;
- English is not their primary language; and
- the concept of insurance and preventive care is new to them.

Outreach Grantees have been successful in reaching the uninsured by establishing contact with the uninsured at clinics, emergency rooms, and community events and then using extensive follow-up to ensure they complete the application process.

Key Measures

⇒ Cost increases in Minnesota health care programs.

More information on Department of Human Services (DHS) measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

Other Health Care Grants is funded from appropriations from the General Fund and Health Care Access Fund and from federal funds.

Contact

For more information on Health Care Grants-Other Assistance, contact

- Assistant Commissioner for Health Care Brian Osberg, (651) 284-4388
- Health Care Eligibility and Access Director Kathleen Henry, (651) 296-8818

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: HEALTH CARE GRANTS
Activity: OTHER HEALTH CARE GR

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	697	1,037	1,037	1,037	2,074
Technical Adjustments					
Current Law Base Change			2,216	2,716	4,932
Program/agency Sunset			(694)	(694)	(1,388)
Subtotal - Forecast Base	697	1,037	2,559	3,059	5,618
Total	**697**	**1,037**	**2,559**	**3,059**	**5,618**
Health Care Access					
Current Appropriation	750	750	750	750	1,500
Subtotal - Forecast Base	750	750	750	750	1,500
Total	**750**	**750**	**750**	**750**	**1,500**
Expenditures by Fund					
Direct Appropriations					
General	317	1,507	2,559	3,059	5,618
Health Care Access	112	0	750	750	1,500
Statutory Appropriations					
Special Revenue	621	2,869	2,050	2,050	4,100
Federal	374	730	730	730	1,460
Total	**1,424**	**5,106**	**6,089**	**6,589**	**12,678**
Expenditures by Category					
Other Operating Expenses	205	365	365	365	730
Payments To Individuals	5	1,464	300	300	600
Local Assistance	1,214	3,277	5,424	5,924	11,348
Total	**1,424**	**5,106**	**6,089**	**6,589**	**12,678**

Program Description

Health Care Management is the administrative support component of Basic Health Care Grants. It is responsible for policy development and implementation, enrollment, purchasing, payment, and quality assurance for health care services. Health Care Management coordinates with Continuing Care Management on the Medicaid-funded activities within Continuing Care Grants.

Budget Activities Included:

⇒ Health Care Policy Administration

⇒ Health Care Operations

HUMAN SERVICES DEPT

Program: HEALTH CARE MANAGEMENT

Program Summary

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	24,834	20,944	20,944	20,944	41,888
Technical Adjustments					
Current Law Base Change			(216)	(133)	(349)
Subtotal - Forecast Base	24,834	20,944	20,728	20,811	41,539
Governor's Recommendations					
Medicare Modernization Act Changes		0	251	1,501	1,752
Pharmaceutical Purchasing		0	38	0	38
Hospital Rate Reduction		0	7	0	7
Better Manage Health Care Costs		0	3,912	3,470	7,382
Improve Mental Health Coverage		0	108	85	193
Total	**24,834**	**20,944**	**25,044**	**25,867**	**50,911**
Health Care Access					
Current Appropriation	14,522	15,793	15,793	15,793	31,586
Technical Adjustments					
Current Law Base Change			(28)	(28)	(56)
Subtotal - Forecast Base	14,522	15,793	15,765	15,765	31,530
Governor's Recommendations					
Restructure MHCP Eligibility		0	866	0	866
Better Manage Health Care Costs		0	2,787	1,885	4,672
Total	**14,522**	**15,793**	**19,418**	**17,650**	**37,068**
Expenditures by Fund					
Direct Appropriations					
General	8,923	11,693	25,044	25,867	50,911
Health Care Access	13,307	14,188	19,418	17,650	37,068
Statutory Appropriations					
Special Revenue	48,403	68,547	26,139	27,113	53,252
Federal	545	296	277	277	554
Total	**71,178**	**94,724**	**70,878**	**70,907**	**141,785**
Expenditures by Category					
Total Compensation	40,611	46,214	40,832	37,487	78,319
Other Operating Expenses	30,561	48,510	28,757	32,400	61,157
Other Financial Transactions	6	0	0	0	0
Transfers	0	0	1,289	1,020	2,309
Total	**71,178**	**94,724**	**70,878**	**70,907**	**141,785**
Expenditures by Activity					
Health Care Administration	4,819	7,421	11,878	11,247	23,125
Health Care Operations	66,359	87,303	59,000	59,660	118,660
Total	**71,178**	**94,724**	**70,878**	**70,907**	**141,785**
Full-Time Equivalents (FTE)	**669.7**	**700.0**	**763.0**	**769.0**	

Activity Description

Health Care Administration is responsible for developing and implementing health care policy related to Basic Health Care Grants.

Population Served

In an average month in FY 2004, approximately 660,000 Minnesotans were enrolled in Minnesota's publicly-funded health care programs.

Health Care Administration works with many entities to serve enrollees including

- 36,000 health care providers, including eight managed health care plans;
- more than 24 state health care professional organizations;
- the federal Centers for Medicare and Medicaid Services; and
- Minnesota's counties and tribes.

Activity at a Glance

- Develops health care policy for services to approximately 660,000 people served by Minnesota Health Care Programs
- Negotiates with service providers on contracts to serve enrollees
- Determines rates for services and works with the health care marketplace to get best coverage at the most affordable prices
- Consults with the federal government to stay in compliance with federal law and negotiates waivers to current program rules
- Monitors health care outcomes for enrollees

Services Provided

Health Care Administration is responsible for

- developing health care program policy and leading implementation of policy initiatives;
- developing payment policies, including fee-for-service and managed care rates, that promote cost-effective delivery of quality services to Medical Assistance (MA), General Assistance Medical Care (GAMC), MinnesotaCare, and Prescription Drug Program (PDP) enrollees;
- monitoring health plans to ensure contract compliance, value, and access;
- conducting surveys and research to monitor quality of care provided and health status of program enrollees;
- working with the federal government to ensure compliance with Medicaid laws and rules;
- negotiating waivers to federal laws and rules to allow expanded access and coverage, payment initiatives, enhanced federal matching funds, and demonstration projects to improve care and services for various enrollee groups;
- working with various partners to plan and implement changes needed to comply with the federal Health Insurance Portability and Accountability Act (HIPAA);
- providing oversight of county and tribal administration of state policies and rules; and
- planning and development of improved eligibility and enrollment systems, including a planned web-based HealthMatch system to make programs more accessible and administration more efficient.

Historical Perspective

Minnesota is consistently a national leader in promoting and implementing policy and payment initiatives that improve access, quality, and cost-effectiveness of services provided through publicly-funded health care programs.

Changes to health care program eligibility over the past 15 years—a combination of federally-mandated and state-initiated expansions—have improved access to health care for low-income, special needs, and uninsured Minnesotans. At the same time, program eligibility requirements have become more complex and resource intensive for the department.

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

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

Finally, as the department increasingly contracts for day-to-day administration of primary health care services, more attention can be given to initiatives that better manage rapidly increasing health care costs. For example, the Health Care Policy Administration has recently implemented unique volume-based purchasing agreements within fee-for-service. Legislation passed in 2002 also directs administrators to seek additional rebate agreements with prescription drug manufacturers to help contain one of the greatest cost factors in the Medicaid budget.

Key Measures

⇒ Cost increases in Minnesota health care programs.
⇒ Inpatient hospital average monthly cost per enrollee.
⇒ Pharmacy average monthly cost per enrollee.

More information on Department of Human Services measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

Health Care Administration is primarily funded with appropriations from the General Fund and Health Care Access Fund and from federal funds.

Contact

For more information on Health Care Administration, contact

- Assistant Commissioner for Health Care Brian Osberg, (651) 284-4388
- Health Care Eligibility and Access Director Kathleen Henry, (651) -296-8818
- Performance Measurement and Quality Improvement Director Vicki Kunerth, (651) 215-5755

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: HEALTH CARE MANAGEMENT
Activity: HEALTH CARE ADMINISTRATION

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	5,523	5,003	5,003	5,003	10,006
Technical Adjustments					
Current Law Base Change			(216)	(133)	(349)
Subtotal - Forecast Base	5,523	5,003	4,787	4,870	9,657
Governor's Recommendations					
Medicare Modernization Act Changes		0	76	501	577
Better Manage Health Care Costs		0	3,443	3,156	6,599
Improve Mental Health Coverage		0	85	85	170
Total	**5,523**	**5,003**	**8,391**	**8,612**	**17,003**
Health Care Access					
Current Appropriation	1,066	745	745	745	1,490
Subtotal - Forecast Base	1,066	745	745	745	1,490
Governor's Recommendations					
Better Manage Health Care Costs		0	2,737	1,885	4,622
Total	**1,066**	**745**	**3,482**	**2,630**	**6,112**
Expenditures by Fund					
Direct Appropriations					
General	3,511	6,553	8,391	8,612	17,003
Health Care Access	699	745	3,482	2,630	6,112
Statutory Appropriations					
Special Revenue	284	104	5	5	10
Federal	325	19	0	0	0
Total	**4,819**	**7,421**	**11,878**	**11,247**	**23,125**
Expenditures by Category					
Total Compensation	2,620	3,261	6,503	6,928	13,431
Other Operating Expenses	2,193	4,160	5,375	4,319	9,694
Other Financial Transactions	6	0	0	0	0
Total	**4,819**	**7,421**	**11,878**	**11,247**	**23,125**
Full-Time Equivalents (FTE)	**31.6**	**33.4**	**92.4**	**98.4**	

Activity Description

Health Care Operations provides the infrastructure necessary for effective and efficient health care purchasing and delivery for Basic Health Care Grants. This includes administering the Medicaid Management Information System (MMIS), which is a centralized medical payment system supporting other department functions, such as administering managed care contracts, conducting eligibility determinations, and conducting quality improvement and data analysis program management.

Activity at a Glance

- Processes over 22.3 million fee-for-service medical claims annually
- Collects or avoids costs amounting to $105 million from third-party insurers liable for some payment of services provided to program enrollees
- Operates MMIS

Population Served

Health Care Operations makes payments to providers, health plans, and, in certain cases, counties for the more than 640,000 Minnesotans enrolled in Medical Assistance (MA), General Assistance Medical Care (GAMC), MinnesotaCare, and Prescription Drug Program (PDP). In doing so, Health Care Operations works directly with approximately 41,000 health care service providers, including inpatient and outpatient hospitals, nursing homes, dentists, physicians, mental health professionals, home care providers, and pharmacists;

- approximately 24 health care provider professional organizations;
- financial and social services staff in Minnesota's 87 counties;
- health plans and other insurers; and
- the federal Centers for Medicare and Medicaid Services.

Services Provided

Health Care Operations is responsible for

- operating centralized payment systems MMIS for MA, MinnesotaCare, GAMC and PDP;
- maintaining health care provider enrollment agreements;
- supporting enrollee communication and outreach including benefit statements, renewal notices, and informational materials;
- maintaining online system availability for claims operation, customer services, and eligibility verification for 41,000 providers;
- supporting enhanced electronic claim activity to increase processing efficiency and decrease administrative costs, including maintaining a viable point-of-sale system for pharmacy;
- developing HealthMatch, the department's planned web-based application and eligibility system for publicly funded health care programs;
- operating a web-based electronic commerce environment for health care claim submission and other government-to-business electronic transactions;
- supporting the collection of premiums for MinnesotaCare and MA for Employed Persons with Disabilities (MA-EPD), spenddowns for Minnesota Senior Health Options and Minnesota Disability Health Options, and development of financial control programs capable of supporting additional premium-based health care purchasing concepts;
- identifying all liable third parties required to pay for medical expenses before expenditure of state funds and recovering costs from other insurers, which includes maximizing Medicare participation in the cost of all services for dually-eligible enrollees, with emphasis on long-term care and home health services; and
- administering the medical care surcharge to ensure maximum receipt of surcharge funds from nursing care facilities and inpatient hospitals in compliance with federal laws and regulations.

Historical Perspective

The current MMIS was implemented in 1994, replacing a system that had been operational since 1974. Since that time the number of fee-for-service claims has grown to 22.3 million in FY 2003, and the number of encounter claims (record of a service provided) from prepaid managed care plans has grown to 17 million in FY 2003. Complexity in health care delivery strategies and in eligibility criteria to ensure focused eligibility for very specific populations has required that MMIS be flexible and scalable. In addition, the accelerated rate of change in

computing technology and the movement toward electronic government services for citizens has required ongoing strategic investments in health care systems.

Key Measures

⇒ Cost increases in Minnesota health care programs.
⇒ Inpatient hospital average monthly cost per enrollee.
⇒ Pharmacy average monthly cost per enrollee.

More information on Department of Human Services (DHS) measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

Health Care Operations is funded primarily with appropriations from the General Fund and Health Care Access Fund and from federal funds.

Contact

For more information on Health Care Operations, contact

- Assistant Commissioner for Health Care Brian Osberg, (651) 284-4388
- Health Care Operations Director Larry Woods, (651) 296-2719

Information is also available on the DHS website: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: HEALTH CARE MANAGEMENT
Activity: HEALTH CARE OPERATIONS

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	19,311	15,941	15,941	15,941	31,882
Subtotal - Forecast Base	19,311	15,941	15,941	15,941	31,882
Governor's Recommendations					
Medicare Modernization Act Changes		0	175	1,000	1,175
Pharmaceutical Purchasing		0	38	0	38
Hospital Rate Reduction		0	7	0	7
Better Manage Health Care Costs		0	469	314	783
Improve Mental Health Coverage		0	23	0	23
Total	**19,311**	**15,941**	**16,653**	**17,255**	**33,908**
Health Care Access					
Current Appropriation	13,456	15,048	15,048	15,048	30,096
Technical Adjustments					
Current Law Base Change			(28)	(28)	(56)
Subtotal - Forecast Base	13,456	15,048	15,020	15,020	30,040
Governor's Recommendations					
Restructure MHCP Eligibility		0	866	0	866
Better Manage Health Care Costs		0	50	0	50
Total	**13,456**	**15,048**	**15,936**	**15,020**	**30,956**
Expenditures by Fund					
Direct Appropriations					
General	5,412	5,140	16,653	17,255	33,908
Health Care Access	12,608	13,443	15,936	15,020	30,956
Statutory Appropriations					
Special Revenue	48,119	68,443	26,134	27,108	53,242
Federal	220	277	277	277	554
Total	**66,359**	**87,303**	**59,000**	**59,660**	**118,660**
Expenditures by Category					
Total Compensation	37,991	42,953	34,329	30,559	64,888
Other Operating Expenses	28,368	44,350	23,382	28,081	51,463
Transfers	0	0	1,289	1,020	2,309
Total	**66,359**	**87,303**	**59,000**	**59,660**	**118,660**
Full-Time Equivalents (FTE)	**638.1**	**666.6**	**670.6**	**670.6**	

Program Description

Continuing Care Grants pay for chronic health care services, long-term care in residential settings, at-home care, and social services for older Minnesotans and people with disabilities. Continuing Care Grants provide an important health care safety net for some of Minnesota's most vulnerable people. Medicaid-funded Continuing Care Grants are coordinated with the department's Health Care Grants.

Budget Activities Included:

⇒ Aging and Adult Services Grants
⇒ Alternative Care Grants
⇒ Medical Assistance (MA) Long Term Care Facilities Grants
⇒ MA Long Term Care Waivers and Home Care Grants
⇒ Mental Health Grants
⇒ Deaf and Hard of Hearing Grants
⇒ Chemical Dependency Entitlement Grants
⇒ Chemical Dependency Non-Entitlement Grants
⇒ Other Continuing Care Grants

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	1,355,356	1,488,336	1,488,336	1,488,336	2,976,672
Technical Adjustments					
Current Law Base Change			240	108	348
End-of-session Estimate			87,122	193,235	280,357
Fund Changes/consolidation			378	378	756
November Forecast Adjustment		(17,554)	(24,038)	(43,771)	(67,809)
Subtotal - Forecast Base	1,355,356	1,470,782	1,552,038	1,638,286	3,190,324
Governor's Recommendations					
Medicare Modernization Act Changes		0	3,408	2,096	5,504
NF Quality and Rate Reform		0	(236)	(1,360)	(1,596)
Manage Waiver Caseload Growth		0	(13,372)	(38,074)	(51,446)
Methamphetamine Treatment		0	300	300	600
Total	**1,355,356**	**1,470,782**	**1,542,138**	**1,601,248**	**3,143,386**
Lottery Cash Flow					
Current Appropriation	1,408	1,408	1,408	1,408	2,816
Technical Adjustments					
Current Law Base Change			(100)	(100)	(200)
Subtotal - Forecast Base	1,408	1,408	1,308	1,308	2,616
Total	**1,408**	**1,408**	**1,308**	**1,308**	**2,616**
Expenditures by Fund					
Direct Appropriations					
General	1,298,056	1,416,826	1,542,138	1,601,248	3,143,386
Lottery Cash Flow	1,383	1,433	1,308	1,308	2,616
Open Appropriations					
Special Revenue	352	667	340	340	680
Statutory Appropriations					
General	30,901	25,670	25,119	24,666	49,785
Special Revenue	88,713	95,326	36,283	39,521	75,804
Federal	1,345,523	1,335,249	1,407,690	1,485,019	2,892,709
Total	**2,764,928**	**2,875,171**	**3,012,878**	**3,152,102**	**6,164,980**
Expenditures by Category					
Other Operating Expenses	548	686	620	642	1,262
Payments To Individuals	2,629,876	2,739,269	2,890,986	3,030,401	5,921,387
Local Assistance	134,504	135,216	121,272	121,059	242,331
Total	**2,764,928**	**2,875,171**	**3,012,878**	**3,152,102**	**6,164,980**

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Expenditures by Activity					
Aging And Adult Services Gr	32,530	34,316	37,701	36,245	73,946
Alternative Care Gr	64,378	60,244	64,222	64,384	128,606
Ma Ltc Facilities Gr	1,258,088	1,097,826	1,076,340	1,064,441	2,140,781
Ma Ltc Waivers & Home Care Gr	1,218,408	1,485,941	1,647,679	1,789,842	3,437,521
Mental Health Gr	65,897	60,473	53,720	53,487	107,207
Deaf & Hard Of Hearing Gr	1,635	1,717	1,445	1,445	2,890
Cd Entitlement Gr	84,739	91,155	95,900	106,378	202,278
Cd Non-Entitlement Gr	11,916	14,070	14,370	14,370	28,740
Other Continuing Care Gr	27,337	29,429	21,501	21,510	43,011
Total	**2,764,928**	**2,875,171**	**3,012,878**	**3,152,102**	**6,164,980**

Activity Description

Aging and Adult Services Grants pay for non-medical social services and provide funding for communities to develop informal services to keep older people engaged in their communities.

Activity at a Glance

- Provides congregate dining to 70,000 people and home-delivered meals to 16,000 people
- Provides social service support services to 135,000 people and health care promotion to 1,500 people
- Supports nearly 20,000 participants who provide services through the Retired and Senior Volunteer Program (RSVP), Foster Grandparents, and Senior Companions
- Provides nearly 44,000 callers with one-to-one information and counseling through the Senior LinkAge Line®
- Funds 165 new projects to expand home and community-based service options for more than 44,000 older people and 375 grants for services for older people

Population Served

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

Services Provided

Aging and Adult Services grants provide

- nutritional services including meals, grocery delivery, and nutrition education counseling;
- transportation, chore services, and other social support services;
- diabetes, blood pressure screening, and other health promotion services;
- mentoring of families and children through older adult volunteer community services projects;
- care and one-on-one attention for special needs children (through the Foster Grandparents Program);
- assistance with daily activities for frail older adults;
- information and assistance through Senior LinkAge Line® and the online database Minnesotahelp.info;
- counseling about Medicare and supplemental insurance choices;
- assistance to consumers to access free or discounted prescription drugs through RxConnect;
- respite and other supportive assistance to family caregivers; and
- expansion and development of more home and community service and housing options.

Historical Perspective

The OAA was passed by Congress in 1965 at the same time the Medicaid program was established (funding nursing home care). The OAA's purpose was to assist elderly people to live as independently as possible and avoid premature institutionalization. The state's federal OAA funds are administered through the Minnesota Board on Aging to provide less formal, community-based services, including volunteer services.

Federal OAA funding is distributed by the proportion of older adults in a state relative to the total older adults in the country. Although Minnesota has seen an increase of more than 50,000 older adults over the last decade, other states have seen a proportionately greater increase --resulting in less federal funding for Minnesota. State funding has been appropriated to supplement federal OAA funds.

Key Measures

⇒ Proportion of public-funded long-term care funds expended in institutional care versus community care settings.

⇒ Proportion of elders served in institutional vs. community settings.

More information on Department of Human Services (DHS) measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

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

Contact

For more information on Aging and Adult Services Grants, contact

- Assistant Commissioner for Continuing Care Loren Colman, (651) 297-4155
- Aging and Adult Services Director James Varpness, (651) 296-1531
- Legislative and Fiscal Operations Manager Sue Banken, (651) 296-5724

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: CONTINUING CARE GRANTS
Activity: AGING AND ADULT SERVICES GR

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	12,998	13,951	13,951	13,951	27,902
Subtotal - Forecast Base	12,998	13,951	13,951	13,951	27,902
Governor's Recommendations					
Medicare Modernization Act Changes		0	3,408	2,096	5,504
Total	**12,998**	**13,951**	**17,359**	**16,047**	**33,406**
Expenditures by Fund					
Direct Appropriations					
General	12,724	13,951	17,359	16,047	33,406
Statutory Appropriations					
Special Revenue	564	586	586	586	1,172
Federal	19,242	19,779	19,756	19,612	39,368
Total	**32,530**	**34,316**	**37,701**	**36,245**	**73,946**
Expenditures by Category					
Payments To Individuals	0	0	3,408	2,096	5,504
Local Assistance	32,530	34,316	34,293	34,149	68,442
Total	**32,530**	**34,316**	**37,701**	**36,245**	**73,946**

Activity Description

Alternative Care (AC) pays for at-home care and community-based services for older adults who are at risk of becoming eligible for Medical Assistance (MA) nursing facility care within six months. It is a state-funded program that gives eligible older adults community-based service choices similar to federally-funded home and community-based programs.

Population Served

To be eligible for AC, a person must be age 65 or older, assessed as needing nursing facility level of care, and have income and assets inadequate to fund nursing facility care for more than 180 days.

Activity at a Glance

- Pays for at-home health and community-based care services for low-income elderly Minnesotans
- Helps older adults stay in their own homes longer by providing an alternative to nursing home care
- Serves 7,950 persons per month
- Costs an average of $808 per person per month, compared to $3,134 per person in a nursing facility

In FY 2003, AC funded services for approximately 7,950 elderly persons per month at an average monthly cost of approximately $808 per person, compared to a $3,134 average monthly cost of nursing facility care. In FY 2003, a total of 12,397 persons received AC funding at an annual cost of $6,441 per recipient.

Services Provided

Alternative Care provides funding for

- respite care, both in-home and at approved facilities, to provide a break for caregivers;
- case management to ensure that care provided is appropriate;
- adult day care;
- personal care services to assist with activities of daily living;
- homemaker services;
- companion service to enhance quality of life;
- assisted living;
- caregiver training and education to provide caregivers with the knowledge and support necessary to adequately care for an elderly person;
- chore services to provide assistance with heavy household tasks such as snow shoveling;
- home health nursing and aide services;
- transportation to AC-related services and community integration;
- nutrition services;
- residential care services for people living in a board and lodging setting;
- adult foster care for people living in licensed foster care;
- medically necessary supplies and equipment;
- telehomecare services to monitor the health status of people in their own homes as an alternative to home visits; and
- other consumer directed services and discretionary services that are part of the person's plan of care.

Historical Perspective

The AC program was implemented in 1981. Its purpose is to provide older adults at risk of nursing facility placement with home and community-based services to assist them to remain at home. Funding is allocated for local lead agencies to provide for service delivery under individual service plans and manage their allocations to serve eligible persons. There were three major legislative changes made to the program effective 7-1-03 which resulted in about a 30% case load reduction during FY 2004. The changes reduced eligibility, increased client contributions, and instituted liens and estate recovery.

Key Measures

⇒ Proportion of elders served in institutional vs. community settings.
⇒ Proportion of public-funded long-term care funds expended in institutional vs. community settings.

More information on Department of Human Services (DHS) measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

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

Contact

For more information on Alternative Care Program, contact

- Assistant Commissioner for Continuing Care Loren Colman, (651) 297-4155
- Aging and Adult Services Director James Varpness, (651) 296-1531
- Legislative and Fiscal Operations Sue Banken, (651) 296-5724

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: CONTINUING CARE GRANTS
Activity: ALTERNATIVE CARE GR

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	75,206	66,351	66,351	66,351	132,702
Technical Adjustments					
Current Law Base Change			1,073	1,174	2,247
Subtotal - Forecast Base	75,206	66,351	67,424	67,525	134,949
Total	**75,206**	**66,351**	**67,424**	**67,525**	**134,949**
Expenditures by Fund					
Direct Appropriations					
General	64,378	57,073	60,986	61,075	122,061
Statutory Appropriations					
General	0	3,171	3,236	3,309	6,545
Total	**64,378**	**60,244**	**64,222**	**64,384**	**128,606**
Expenditures by Category					
Payments To Individuals	64,378	60,244	64,222	64,384	128,606
Total	**64,378**	**60,244**	**64,222**	**64,384**	**128,606**

Activity Description

Medical Assistance (MA) Long-Term Care Facilities Grants pays for nursing facility (NF) care, intermediate care facilities for people with mental retardation or related conditions (ICF/MR), and day training and habilitation (DT&H) for people who are ICF/MR residents.

Activity at a Glance

- Provides nursing facility and boarding care home services to 38,000 people per month
- Provides ICFs/MR services to 2,300 residents per month
- Provides DT&H services to 11,800 people per year

Population Served

MA enrollees who require nursing facility or ICF/MR services are eligible. There are nearly 644 long-term care (LTC) facilities that serve about 40,000 people per month in this budget activity. The following data are from FY 2003:

⇒ There were 417 MA-certified NF and boarding care homes. MA-certified NFs and boarding care homes served approximately 38,000 people per month at a daily average rate of $130 per person. About two-thirds of the residents received MA and one-third privately pay for their care, receive Medicare, or have other insurance.

⇒ There were 227 MA-certified ICFs/MR. ICFs/MR served an average of 2,298 recipients per month. The monthly average payment was $5,669 per resident. In FY 2003, 14 ICFs/MR were closed and 172 additional beds were decertified.

Funding for DT&H services is contained in three different budget activities: MA Long-Term Care Facilities Grants for those people residing in ICFs/MR, MA Long-Term Care Waivers and Home Care Grants for mental retardation or related condition waiver recipients, and Children and Community Services Grants available to all eligible people. There are 267 DT&H service vendors in Minnesota. In total, DT&H programs serve approximately 11,800 people with disabilities per year. Approximately 1,960 ICF/MR recipients per month receive DT&H services at a monthly average MA payment of $1,558 per person.

People who reside in an ICF/MR now have the flexibility and choice to receive an alternative habilitative service during the day that best meets their needs. This means that ICF/MR recipients have a choice of day services, as do people who receive a home and community-based waiver.

Services Provided

Nursing facilities provide 24-hour care and supervision in a residential-based setting. Housing and all other services are provided as a comprehensive package, including, but not limited to

- nursing and nursing assistant services;
- help with activities of daily living and other care needs;
- housing;
- meals;
- medication administration;
- activities and social services;
- supplies and equipment;
- housekeeping, linen, and personal laundry; and
- therapy services (at an extra cost).

ICFs/MR provide 24-hour care, habitation, training, and supervision to persons with mental retardation or related condition. ICFs/MR are located in 67 counties and range in size from four beds to 64 beds. Most ICFs/MR are less medically oriented than nursing facilities and provide outcome-based services in response to the needs of a person. All ICFs/MR must make available to each person functional skill development, opportunities for development of decision making skills, opportunities to participate in the community, and reduced dependency on care providers. Like nursing facilities, an ICF/MR provides a package of services, which include housing and food.

DT&H services are licensed supports that provide persons with mental retardation or a related condition help to develop and maintain life skills, participate in the community, and engage in productive and satisfying activities of their own choosing. DT&H services include: supervision, training and assistance in the areas of self-care, communication, socialization and behavior management; supported employment and work-related activities; community integrated activities, including the use of leisure and recreation time; and training in community survival skills, money management, and therapeutic activities that increase adaptive living skills of a person.

Historical Perspective

Use of NFs grew rapidly with the establishment of the federal Medicaid program in the 1960s. The availability of federal matching funds for the state's publicly-funded health care programs provided an incentive for this investment. Medicaid expenditures grew as people who qualified for NF services accessed this entitlement. In the mid-1980s, a moratorium was placed on development of new NFs and efforts were made to develop less expensive home and community-based alternatives. Today, more older adults are choosing to receive services in their own homes. NF utilization has been declining and NFs are more often used for short-term care and rehabilitation following hospitalization. Recent efforts to "rightsize" the industry and to provide financial stability include provisions for bed layaway and planned bed closure and higher rates for short lengths of stay.

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

DT&H services have been in operation in the state for over 35 years. They are a mandatory service for people with mental retardation or a related condition. DT&H programs on average provide 195 days of service per year.

Key Measures

⇒ Proportion of nursing home days paid by funding source.
⇒ Proportion of elders served in institutional vs. community settings.
⇒ Proportion of public-funded long-term care funds expended in institutional vs. community settings.

More information on Department of Human Services (DHS) measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

MA Long Term Care Facilities Grants is funded with appropriations from the General Fund and from federal Medicaid funds.

Contact

For more information on MALTC Facility Grants, contact

- Assistant Commissioner for Continuing Care Loren Colman, (651) 297-4155
- State Medicade Director Christine Bronson, (651) 296-4332
- Nursing Facility Rates and Policy Division Director Bob Held, (651) 215-5761
- Disability Services Director Shirley York, (651) 582-1805
- Legislative and Fiscal Operations Manager Sue Banken, (651) 296-5724

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: CONTINUING CARE GRANTS
Activity: MA LTC FACILITIES GR

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	513,763	536,321	536,321	536,321	1,072,642
Technical Adjustments					
End-of-session Estimate			(5,241)	105	(5,136)
November Forecast Adjustment		(19,184)	(21,114)	(31,334)	(52,448)
Subtotal - Forecast Base	513,763	517,137	509,966	505,092	1,015,058
Governor's Recommendations					
NF Quality and Rate Reform		0	(236)	(1,360)	(1,596)
Total	**513,763**	**517,137**	**509,730**	**503,732**	**1,013,462**
Expenditures by Fund					
Direct Appropriations					
General	522,969	526,415	516,168	510,182	1,026,350
Statutory Appropriations					
General	30,901	22,499	21,883	21,357	43,240
Federal	704,218	548,912	538,289	532,902	1,071,191
Total	**1,258,088**	**1,097,826**	**1,076,340**	**1,064,441**	**2,140,781**
Expenditures by Category					
Payments To Individuals	1,258,088	1,097,826	1,076,340	1,064,441	2,140,781
Total	**1,258,088**	**1,097,826**	**1,076,340**	**1,064,441**	**2,140,781**

Activity Description

Medical Assistance (MA) long-term care (LTC) waivers and home care grants pay for a collection of medical and health care-related support services that enable low-income Minnesotans, who are elderly or who have disabilities, to live as independently as possible in their communities. LTC waivers refer to home and community-based services available under a federal Medicaid waiver as an alternative to institutional care.

Activity at a Glance

- Provides MA personal care and private duty nursing to 9,200 people
- Provides home health care services to 24,000 people
- Supports 38,500 people, who are at risk of placement in an institution, in the community through long-term care waivers annually

Population Served

Home Care and LTC Waivers serve MA-enrolled people of all ages, including infants and frail older adults. To receive LTC waivers, a person must be at risk of requiring institutional care. Waiver eligibility is linked to a person's need for a 24-hour plan of care that places them at risk of placement in an institutional setting. These programs served the following number of people in FY 2003:

	People Served	Avg. Annual Cost per Person
MA Home Care Services		
Personal Care Assistance (PCA) Services	8,864	$17,772
Private Duty Nursing (PDN) Services	531	$60,582
Home Health Care Services		
Home health aide services	5,791	$2,904
Skilled nursing services	15,072	$1,141
Therapies (Physical Therapy (PT) Occupational (OT), Respiratory, Speech)	1,332	$1,593
Long-Term Care Waivers		
Community Alternative Care (CAC) Waiver	165	$47,143
Community Alternative for Disabled Individuals (CADI) Waiver	8,420	$8,270
Elderly Waiver (EW)	13,399	$6,870
Mental Retardation/Related Conditions Waiver	15,682	$52,073
Traumatic Brain Injury (TBI) Waiver	861	$42,559

Services Provided

Home care includes specific services for people recovering from major illness or making a transition from a hospital or nursing facility back to their home. It also includes a limited continuing care benefit for people with ongoing assistance needs. MA home care services are authorized based on medical necessity and an order by a licensed physician. MA home care services include

- assessments by public health nurses;
- home health aide visits;
- nurse visits;
- private duty nursing services;
- personal care services;
- occupational, physical, speech, and respiratory therapies; and
- medical supplies and equipment.

LTC Waivers, which are also known as home and community-based waiver programs, provide a variety of support services that assist people to live in the community instead of going into or staying in an institutional setting. Available support services include

- caregiver training and education;

- case management;
- consumer-directed community supports;
- behavioral interventions;
- day activity, day habilitation, and vocational supports;
- home-delivered meals;
- home and environmental modifications;
- homemaking and chore services;
- independent living skills training;
- supplies and equipment;
- transportation;
- respite care;
- supportive services in foster care, assisted living, and residential settings; and
- extended MA home care services, including therapies.

Historical Perspective

Home and community-based waivers were established under section 1915(c) of the federal Social Security Act of 1981. These waivers were intended to correct the institutional bias in Medicaid by allowing states to offer a broad range of home and community-based services to people who may otherwise be institutionalized. Minnesota has obtained approval of the waivers described in this activity.

In 1999, the United States Supreme Court in Olmstead v. L.C. clarified that Title II of the American with Disabilities Act (ADA) to include supporting people with disabilities in the most integrated setting possible. The decision applies to people of any age who have a disability.

Consumer-Directed Community Supports (CDCS) is a waiver service that will provide many Minnesotans increased flexibility in determining and designing supports that best meet their needs. In March 2004, the Centers for Medicare and Medicaid Services approved the CDCS waiver. The Department of Human Services (DHS) will begin to implement the CDCS service across all LTC Waivers on 10-1-04 in counties that are already offering this service under the MR/RC Waiver.

Key Measures

⇒ Number of elders served in institutional vs. community settings.
⇒ Proportion of public-funded long-term care funds expended in institutional vs.community settings.
⇒ Proportion of recipients with higher needs.
⇒ Number of waiver recipients receiving consumer-directed supports.

More information on Department of Human Services (DHS) measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

MA Long-Term Care Waivers and Home Care Grants is funded with appropriations from the General Fund and from federal Medicaid funds.

Contact

For more information on MA Long-Term Care Waivers and Home Care Grants, contact

- Assistant Commissioner for Continuing Care Loren Colman, (651) 297-4155
- Legislative and Fiscal Operations Manager Sue Banken, (651) 296-5724
- Disability Services Director Shirley York, (651) 582-1805
- State Medicade Director Christine Branson, (651) 296-4332
- Aging and Adult Services Director James Varpness (651) 296-1531

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: CONTINUING CARE GRANTS
Activity: MA LTC WAIVERS & HOME CARE GR

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	624,631	748,189	748,189	748,189	1,496,378
Technical Adjustments					
End-of-session Estimate			89,587	185,998	275,585
November Forecast Adjustment		1,630	(3,297)	(15,709)	(19,006)
Subtotal - Forecast Base	624,631	749,819	834,479	918,478	1,752,957
Governor's Recommendations					
Manage Waiver Caseload Growth		0	(13,372)	(38,074)	(51,446)
Total	**624,631**	**749,819**	**821,107**	**880,404**	**1,701,511**
Expenditures by Fund					
Direct Appropriations					
General	617,308	742,970	821,107	880,404	1,701,511
Statutory Appropriations					
Federal	601,100	742,971	826,572	909,438	1,736,010
Total	**1,218,408**	**1,485,941**	**1,647,679**	**1,789,842**	**3,437,521**
Expenditures by Category					
Payments To Individuals	1,218,408	1,485,941	1,647,679	1,789,842	3,437,521
Total	**1,218,408**	**1,485,941**	**1,647,679**	**1,789,842**	**3,437,521**

Activity Description

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

Activity at a Glance

- 19,000 adults receive mental health case management
- Reduces use of hospital care for participants in Adult Mental Health Initiatives: 33% for community hospitals and 67% for state-operated hospitals
- Provides community support services to 12,000 people
- Provides residential treatment to 3,000 people
- Provides crisis housing to 400 people
- Provides services to 8,300 homeless people
- Provides compulsive gambling treatment to 1,000 people

Population Served

Approximately 94,000 Minnesota adults have serious and persistent mental illness (SPMI). Of this group, 71,000 adults with SPMI are estimated to need publicly-subsidized mental health services. This compares to about 26,000 people who actually received these services in 2002 (based on county reports to the Community Mental Health Reporting System).

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

Services Provided

Mental Health Grants support a variety of services:

⇒ *Adult Mental Health Initiative/Integrated Fund* supports local planning and development to expand community-based services and to develop alternative service delivery models to reduce reliance on facility-based care. As part of this initiative, regional treatment center staff are integrating into the community mental health delivery system. In most of the state, this also includes integration of the separate grants listed below. Integration of grants at the county level allows administration to be more effective and efficient.

⇒ *Grants for Community Support Services for Adults with Serious and Persistent Mental Illness (Adult Rule 78)* are awarded to counties for client outreach, medication monitoring, independent living skills development, employability skills development, psychosocial rehabilitation, day treatment, and case management if MA is inadequate or not available. These funds are allocated by formula, primarily based on a county's population. In addition, these grants include a separate allocation which is based on the amount each county formerly received as the state share of MA case management, adjusted by the number of people now being served by each county. Effective 7-1-99, counties became responsible for the non-federal share of MA case management, but they can use this "former state share" grant to meet part of that responsibility.

⇒ *Adult Residential Grants (Rule 12)* pay for residential facilities staff to provide treatment to people with mental illness. County boards apply for Rule 12 funds on behalf of local residential facilities to assist in meeting program-licensing standards.

⇒ *Crisis Housing* provides financial help when people are hospitalized and need help to maintain their current housing. Eligible people need to be in inpatient care for up to 90 days and have no other help to pay housing costs.

⇒ *Moose Lake Regional Treatment Center (RTC) Alternatives* pays for non-MA contract beds in community hospitals up to 45 days per admission for people who are committed or who would be committed if these community services were not available. This is part of a package of expanded community mental health services for the area formerly served by the Moose Lake RTC (which closed in 1995).

⇒ *Federal Mental Health Block Grant* funds are used to demonstrate innovative approaches based on best practices that, based on evaluation results, could be implemented statewide. Of the federal block grant,

Minnesota has allocated about half for children's mental health. At least 25% is used for Indian mental health services, not more than 15% for planning and evaluation, and not more than 5% for statewide administration. Grants provided for Indian mental health services fund nine projects on reservations and two in the metro.

⇒ *Projects for the Homeless (PATH)* funds, from the federal McKinney Act, are provided to counties to address mental illness among the homeless. Grants to counties are made in combination with Rule 78 Community Support Program funds.

⇒ *Mental Health Services for People Affected by Natural Disasters* includes federal grants for crisis counseling for people affected by presidentially-declared disasters such as the April 1997 floods, the April 1998 tornadoes, the July 2000 tornado, and the June 2002 floods.

⇒ *Compulsive Gambling Treatment and Education* funds inpatient and outpatient treatment programs on an individual client, fee-for-service basis. The program also pays for research, a resource library, public education and awareness efforts, in-service training for treatment providers, and a statewide toll-free, 24-hour helpline. In state FY 2002, the helpline received 3,900 calls.

Historical Perspective

Federal restrictions that prohibit the use of MA for adults in Institutions for Mental Diseases (IMDs) have required the state to rely on state General Fund grant programs to a much larger degree than programs serving other populations, such as the elderly or developmentally disabled. During the past four years, Minnesota has made progress in expanding the range of non-residential community mental health services and maximizing federal reimbursement for these services. The 2003 session also authorized the Department of Human Services (DHS) to seek federal approval for expanded MA coverage of intensive residential treatment and assertive community treatment teams, using existing state grant funds as the match. This expanded coverage is being implemented during FY 2005 (as projected earlier) and is being coordinated with the movement of state-operated services out of institutional settings into the community.

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

Key Measures

⇒ Percent of persons with serious and persistent mental illness served in institutional settings.

⇒ Average days in an institutional setting per recipient with mental illness.

⇒ Percent of persons with serious and persistent mental illness readmitted to a hospital setting within 30 days of discharge.

More information on Department of Human Services measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

Mental Health Grants are funded with appropriations from the state General Fund, Lottery Fund, and Special Revenue Fund, as well as from federal funds.

Contact

For further information about Mental Health Grants, please contact

- Assistant Commissioner for Chemical and Mental Health Services Wes Kooistra, (651) 297-5298
- Mental Health Director Sharon Autio, (651) 582-1810
- Legislation and Fiscal Operations Manager Don Allen, (651) 297-5298

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: CONTINUING CARE GRANTS
Activity: MENTAL HEALTH GR

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	53,479	46,551	46,551	46,551	93,102
Technical Adjustments					
Current Law Base Change			(788)	(1,021)	(1,809)
Fund Changes/consolidation			378	378	756
Subtotal - Forecast Base	53,479	46,551	46,141	45,908	92,049
Total	**53,479**	**46,551**	**46,141**	**45,908**	**92,049**
Lottery Cash Flow					
Current Appropriation	1,408	1,408	1,408	1,408	2,816
Technical Adjustments					
Current Law Base Change			(100)	(100)	(200)
Subtotal - Forecast Base	1,408	1,408	1,308	1,308	2,616
Total	**1,408**	**1,408**	**1,308**	**1,308**	**2,616**
Expenditures by Fund					
Direct Appropriations					
General	58,411	52,402	46,141	45,908	92,049
Lottery Cash Flow	1,383	1,433	1,308	1,308	2,616
Open Appropriations					
Special Revenue	352	667	340	340	680
Statutory Appropriations					
Federal	5,751	5,971	5,931	5,931	11,862
Total	**65,897**	**60,473**	**53,720**	**53,487**	**107,207**
Expenditures by Category					
Other Operating Expenses	99	230	140	140	280
Local Assistance	65,798	60,243	53,580	53,347	106,927
Total	**65,897**	**60,473**	**53,720**	**53,487**	**107,207**

Activity Description

Deaf and Hard of Hearing Grants provide core services that enable Minnesotans who are deaf, deafblind, or hard of hearing gain and maintain the ability to live independently and participate in their communities.

Activity at a Glance

- Serves 19,000 people a year
- Provides sign language interpreter and other services that allow people to access essential services, including emergency and crisis services
- Funds specialized services that allow some of the most vulnerable Minnesotans, including those who are deafblind and seriously and persistently mentally ill, to live in their communities

Population Served

There are approximately 67,000 Minnesotans who are deaf and 497,000 with some hearing loss. These grants serve

- people in need of sign language interpreting services;
- children and adults who have a sensory loss of hearing and vision (deafblind);
- people who have a dual hearing loss and a mental illness; and
- children with a hearing loss ages 0-21 in need of specialized psycho-social assessments.

Services Provided

⇒ Sign language interpreter referral services allow deaf, hard of hearing, and deafblind Minnesotans to receive the interpreter services to access core services such as courts, educational programs, mental health services, law enforcement, medical care, and more. Interpreter referral services are provided statewide through grants awarded to community-based vendors. Services provided include

- coordinating and placing qualified sign language and oral and cued-speech interpreters;
- coordinating emergency on-call interpreters;
- providing technical assistance to agencies and consumers on how to work effectively with interpreters; and
- building capacity to increase the number of qualified and certified interpreters throughout greater Minnesota.

⇒ Deafblind grants provide support to allow adults who are both deaf and blind to live independently rather than in nursing homes or other institutional settings. They also provide deafblind children and their families with services that result in enhanced community integration and/or that teach siblings and parents the skills needed to support the deafblind child in their families. Services are provided through statewide grants awarded to community-based, specialized service providers and through a pilot program using a consumer-directed service model. Services include

- client needs assessments;
- one-to-one support services for deafblind adults;
- interveners and family education specialists for deafblind children and their families; and
- advocacy services for those experiencing difficulties receiving needed services.

⇒ Specialized mental health services are provided through statewide grants awarded to community-based, specialized service providers to assist deaf, hard of hearing, and deafblind Minnesotans with serious and persistent mental illness to live in their communities. Services include

- Residential, community-based support services in communication-accessible group home settings;
- community support services;
- inpatient and outpatient therapy, family counseling services, and service providers who are skilled in communicating with deaf, hard of hearing, and deafblind people;
- specialized psychological assessments that are not otherwise available and that serve as the foundation for determining needed service and intervention strategies; and
- community educational opportunities for families, schools, and mental health providers.

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Historical Perspective

In the early 1980s, the Minnesota Legislature passed the Hearing-Impaired Services Act (now called the Deaf and Hard of Hearing Services Act) to ensure that deaf, deafblind and hard of hearing people have access to appropriate human services statewide. This Act established the Deaf and Hard of Hearing Services regional offices to provide direct services to consumers and to house the Telephone Equipment Distribution (TED) program. TED provides adaptive equipment to people with a hearing or speech loss or mobility impairment to access the telephone system. The TED program is funded by special revenues through an interagency agreement with the Department of Commerce. In addition, the legislature has appropriated grant funds to address highly specialized services needs for targeted segments of the deaf, hard of hearing and deafblind populations.

In 1985 the Minnesota Legislature created the Minnesota Commission Serving Deaf and Hard of Hearing (MCDHH), a 15-member, statewide advisory council to advise the governor and state agencies about the needs and concerns of deaf and hard of hearing consumers, including their families.

Key Measures

⇒ Percent of interpreter referral requests filled in greater Minnesota.

⇒ Percent of deaf and hard or hearing persons with serious and persistent mental illness served in institutional settings.

⇒ Average days in an institutional setting per deaf and hard or hearing recipient with mental illness.

⇒ Percent of deaf and hard of hearing persons with serious and persistent mental illness readmitted to a hospital setting within 30 days of discharge.

More information on Department of Human Services (DHS) measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

Deaf and Hard of Hearing Grants are funded with appropriations from the General Fund.

Contact

For more information on Deaf and Hard of Hearing Grants, contact

- Assistant Commissioner for Continuing Care Loren Colman, (651) 297-4155
- Deaf and Hard of Hearing Services Director Bruce Hodek, (651) 296-3980 (voice) or (651) 297-1392 (TTY)
- Legislative and Fiscal Operations Manager Sue Banken, (651) 296-5724

Information also is available on the DHS web site: http://www.dhs.state.mn.us.

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	1,719	1,490	1,490	1,490	2,980
Technical Adjustments					
Current Law Base Change			(45)	(45)	(90)
Subtotal - Forecast Base	1,719	1,490	1,445	1,445	2,890
Total	**1,719**	**1,490**	**1,445**	**1,445**	**2,890**
Expenditures by Fund					
Direct Appropriations					
General	1,635	1,717	1,445	1,445	2,890
Total	**1,635**	**1,717**	**1,445**	**1,445**	**2,890**
Expenditures by Category					
Other Operating Expenses	5	0	0	0	0
Local Assistance	1,630	1,717	1,445	1,445	2,890
Total	**1,635**	**1,717**	**1,445**	**1,445**	**2,890**

Activity Description

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

Population Served

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

Activity at a Glance

- Provides coverage of CD treatment for 25,000
- Average cost per admission is $3,361
- 310 treatment programs participate in the CCDTF
- Approximately 50% of all treatment admissions in the state are paid for by the CCDTF
- The number of treatment admissions has increased by an average of 7% per year over the last three years

The CCDTF has three tiers of eligibility, although this budget activity covers only Tier I:

⇒ Tier I is the entitlement portion. Eligible individuals are people who are enrolled in Medical Assistance (MA) or General Assistance Medical Care (GAMC), receive Minnesota Supplemental Assistance (MSA), or meet the MA, GAMC, or MSA income limits (100% of federal poverty guidelines).

⇒ Tier II includes people who are not eligible for MA, but whose income does not exceed 215% of federal poverty guidelines. (This tier is addressed in the CD Non-Entitlement Grants activity page.)

⇒ Tier III includes people with incomes between 215% and 412% of federal poverty guidelines. (This tier has not been funded in recent years.)

Services Provided

The CCDTF pays for four types of chemical dependency treatment

- inpatient chemical dependency treatment;
- outpatient chemical dependency treatment;
- halfway house services; and
- extended care treatment.

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

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

CCDTF providers received a 1% rate reduction effective 7-1-03, and their rates are frozen through 6-30-05.

In January 2005 a new treatment licensing rule will be implemented. Services will no longer be licensed on the basis of the levels of care described above. A new assessment standard is also being developed that will assess individuals more on the basis of individual need for service, rather than placing an individual into one of the four levels of care.

Historical Perspective

The CCDTF was created in 1988 to consolidate a variety of funding sources for chemical dependency treatment services for low-income, chemically-dependent Minnesota residents. The CCDTF combines previously separated funding sources – MA, GAMC, General Assistance, state appropriations, and federal block grants - into a single

fund with a common set of eligibility criteria. Counties pay at least 15% of treatment costs to maintain a local maintenance of effort.

Since its inception, the entitlement portion of the CCDTF (Tier I) has served about 18,500 clients annually.

Key Measures

⇒ Percent of adults and minors who complete chemical dependency treatment.
(Other measures under development)

More information on Department of Human Services measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

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

Contact

For more information on Chemical Dependency Entitlement Grants, contact

- Assistant Commissioner for Chemical and Mental Health Services Wes Kooistra, (651) 296-6993
- Chemical Health Director Donald Eubanks, (651) 582-1856
- Legislative and Fiscal Operations Manager Don Allen, (651) 297-5298

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	57,612	60,034	60,034	60,034	120,068
Technical Adjustments					
End-of-session Estimate			2,776	7,132	9,908
November Forecast Adjustment		0	373	3,272	3,645
Subtotal - Forecast Base	57,612	60,034	63,183	70,438	133,621
Total	**57,612**	**60,034**	**63,183**	**70,438**	**133,621**
Expenditures by Fund					
Direct Appropriations					
General	0	0	63,183	70,438	133,621
Statutory Appropriations					
Special Revenue	84,739	91,155	32,717	35,940	68,657
Total	**84,739**	**91,155**	**95,900**	**106,378**	**202,278**
Expenditures by Category					
Payments To Individuals	82,850	89,179	93,894	104,202	198,096
Local Assistance	1,889	1,976	2,006	2,176	4,182
Total	**84,739**	**91,155**	**95,900**	**106,378**	**202,278**

Activity Description

Chemical Dependency Non-entitlement Grants pay for chemical dependency treatment provided to low-income individuals ineligible for entitlement-based treatment, statewide prevention efforts, and culturally appropriate services and support. A combination of state and federal dollars supports this activity.

Activity at a Glance

- Provides treatment services for chemical abuse or dependency for 1,200 people
- Provides prevention services to over 15,500 youth
- Provides intervention and case management services to 1,800 pregnant women and women with children
- Provides training for 2,800 chemical dependency professionals
- Provides intervention and case management services to over 2,500 people

Population Served

Chemical Dependency Non-Entitlement Grants serve

- people who receive treatment through Tier II of the Consolidated Chemical Dependency Treatment Fund (CCDTF);
- youth who receive prevention services;
- pregnant women and women with children who receive intervention and case management services;
- chemical dependency professionals who receive training and information from seminars; and
- people who receive intervention and case management services.

The CCDTF has three tiers of eligibility. This budget activity covers only Tier II.

⇒ Tier I is the entitlement portion. Eligible individuals are people who are enrolled in Medical Assistance (MA), General Assistance Medical Care (GAMC), receive Minnesota Supplemental Assistance (MSA), or meet the MA, GAMC, or MSA income limits (100% of federal poverty guidelines).

⇒ Tier II includes people who are not eligible for MA or GAMC, do not receive MSA, or do not meet the MA, GAMC or MSA income limits, but whose income does not exceed 215% of federal poverty guidelines. (This tier was not funded in FY 2004-05).

⇒ Tier III includes individuals with incomes between 215% and 412% of federal poverty guidelines. This tier has not been funded in recent years.

Services Provided

State-funded Non-entitlement Grants support

- community drug and alcohol abuse prevention for American Indians; and
- treatment support for American Indians.

Federally-funded Non-entitlement Grants support

- community drug and alcohol abuse prevention for American Indians, African Americans, Asian-Americans, and Hispanic populations;
- women's treatment support program grants which include subsidized housing, transportation, child care, parenting education, and case management;
- case management services to elderly and criminal justice population;
- case management for persons with chronic alcohol and drug abuse conditions and homelessness; and
- statewide prevention resource center that provides alcohol and other drug abuse education, information, and training to Minnesota counties, tribes, local communities, and organizations.

Additional activities include the dissemination of approximately 550,000 pieces of prevention material, 3,000 calls to prevention phone lines, 187,000 web hits on alcohol, tobacco, and other drug abuse prevention, 6,000 requests for information handled by prevention resource centers, and 200 prevention public service announcements were developed and disseminated to over 600 outlets.

Historical Perspective
Tier II and Tier III of the CCDTF were established in 1988 to create a hierarchy of financial eligibility that prioritized CCDTF service access when state funding was limited. In the early 1990s, Tier II eligibility was restricted to adolescents, pregnant women, and parents with minor children in the home. Since FY 1999, Tier II service needs were funded using resources available in the CCDTF Reserve. Tier II has not been funded in the FY 2004-05 biennium. Approximately 2,500 Tier II eligible individuals have accessed needed chemical dependency treatment services each year. Tier III has not been funded in over 10 years.

Over the last decade, as research studies indicated that the prevalence of substance abuse was higher for certain populations or that some groups did not succeed in chemical dependency treatment at the same rate as the general population, specific improvement efforts were established. These efforts were designed to build prevention strategies and treatment support services that focus on the unique strengths and needs of these various populations. The need for these specialized models of prevention and treatment has grown as counties and tribes recognize the role substance abuse plays in difficult Temporary Assistance to Needy Families and Child Welfare cases.

Key Measures
(Under development)

More information on Department of Human Services (DHS) measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

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

Contact
For more information on Chemical Dependency Non-Entitlement Grants, contact
- Assistant Commissioner for Chemical and Mental Health Services Wes Kooistra, (651) 296-6993
- Chemical Health Director Donald Eubanks, (651) 582-1856
- Legislative and Fiscal Operations Manager Don Allen, (651) 297-5298

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: CONTINUING CARE GRANTS
Activity: CD NON-ENTITLEMENT GR

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	1,055	1,055	1,055	1,055	2,110
Subtotal - Forecast Base	1,055	1,055	1,055	1,055	2,110
Governor's Recommendations					
Methamphetamine Treatment		0	300	300	600
Total	**1,055**	**1,055**	**1,355**	**1,355**	**2,710**
Expenditures by Fund					
Direct Appropriations					
General	1,042	1,055	1,355	1,355	2,710
Statutory Appropriations					
Special Revenue	626	400	400	400	800
Federal	10,248	12,615	12,615	12,615	25,230
Total	**11,916**	**14,070**	**14,370**	**14,370**	**28,740**
Expenditures by Category					
Other Operating Expenses	65	128	128	128	256
Payments To Individuals	626	400	400	400	800
Local Assistance	11,225	13,542	13,842	13,842	27,684
Total	**11,916**	**14,070**	**14,370**	**14,370**	**28,740**

Activity Description

Other Continuing Care Grants includes a variety of programs:

⇒ Family Support Grants (FSG) assist families with access to disability services and supports.

⇒ Consumer Support Grants (CSG) help people with functional limitations and their families purchase supports needed to live as independently as possible.

⇒ Semi-Independent Living Skills (SILS) Grants assist adults with mental retardation or a related condition.

⇒ HIV/AIDS grants provide a menu of services specifically for HIV-infected people to provide early intervention and cost-effective care to prevent or delay enrollment in the Medical Assistance (MA) or General Assistance Medical Care (GAMC) programs.

Activity at a Glance

- Family Support Grants serve 1,500 families at an annual cost of $2,700 per recipient
- Consumer Support Grants serve 260 individuals at an annual cost of $14,500 per recipient
- SILS Grants serve 1,500 adults with disabilities at an annual cost of $5,000 per recipient
- HIV/AIDS programs help
  - ⇒ 1,000 people pay for prescription drugs;
  - ⇒ 700 people pay insurance costs;
  - ⇒ 200 people with dental services;
  - ⇒ 120 people with nutritional services; and
  - ⇒ 1,000 people with case management services

Population Served

⇒ Family Support Grants serve families whose annual adjusted gross income is less than $72,446 and who have a child with mental retardation or a related condition.

⇒ Consumer Support Grant is available for people who are eligible for Medical Assistance (MA), Alternative Care (AC), or FSG.

⇒ Semi-Independent Living Skills serves people who are at least 18 years old, have mental retardation or a related condition, require a level of support that is not at a level that would put them at risk of institutionalization, and require systematic instruction or assistance to manage activities of daily living.

⇒ HIV/AIDS programs serve people living with HIV who have income under 300% of the federal poverty guideline (FPG) and cash assets under $25,000.

Services Provided

⇒ Family Support Grants provide cash to families to offset the higher-than-average cost of raising a child with a certified disability. Families with more than one child with a disability may apply for a grant for each eligible child. The maximum grant per family is $3,000 per year per eligible child.

⇒ Consumer Support Grants help families purchase home care, adaptive aids, home modifications, respite care, and other assistance with the tasks of daily living. Recipients receive a grant amount less than or equal to the state share of the amount of certain long-term care services they would receive under MA, AC, or FSG.

⇒ SILS Grants are used by adults with mental retardation or a related condition to purchase instruction or assistance with nutrition education, meal planning and preparation, shopping, first aid, money management, personal care and hygiene, self-administration of medications, use of emergency resources, social skill development, home maintenance and upkeep, and transportation skills.

⇒ HIV/AIDS programs assist enrollees with premiums to maintain private insurance, co-payments for HIV-related medications, counseling, dental services, the cost of enteral nutrition, and case management.

Historical Perspective

The Consumer Support Grant Program was established in 1995 in response to a growing interest in service alternatives that promoted consumer control and accountability.

The HIV/AIDS program began in 1987. An important element in its creation was the desire to keep private insurance policies in place for HIV+ people and at the same time provide access to a limited scope of additionally needed services and products. The program currently serves more than 1,500 people. The number of people living with HIV in Minnesota has increased as new people are infected and those already infected are living longer. Epidemiological studies show that people contracting HIV are increasingly likely to be poor, women,

people of color, and people with more complex needs and fewer resources who require more assistance. Continually evolving treatments and research make HIV an ever-changing and complex disease to manage. To make access to services more streamlined at the state level, in 2001, responsibility for case management of services to people with HIV was consolidated at the Department of Human Services (DHS). In response to increasing budget pressures the HIV/AIDS program implemented in 2004 a cost sharing and prescription drug co-pay requirement for individuals enrolled in the HIV/AIDS program.

Key Measures

⇒ Proportion of public-funded long-term care funds expended in institutional vs. community settings.
⇒ Minnesota health care programs' cost increases.
⇒ Pharmacy average monthly cost per recipient.

More information on Department of Human Services measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

Other Continuing Care Grants funded with appropriations from the General Fund and from federal funds.

Contact

For more information on Health Care Grants-Other Assistance, contact

- Assistant Commissioner for Continuing Care Loren Colman, (651) 297-4155
- Disabilities Services and HIV/AIDS Director Shirley York, (651) 582-1805
- Legislative & Fiscal Operations Director Sue Banken (651)296-5724

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: CONTINUING CARE GRANTS
Activity: OTHER CONTINUING CARE GR

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	14,893	14,394	14,394	14,394	28,788
Subtotal - Forecast Base	14,893	14,394	14,394	14,394	28,788
Total	**14,893**	**14,394**	**14,394**	**14,394**	**28,788**
Expenditures by Fund					
Direct Appropriations					
General	19,589	21,243	14,394	14,394	28,788
Statutory Appropriations					
Special Revenue	2,784	3,185	2,580	2,595	5,175
Federal	4,964	5,001	4,527	4,521	9,048
Total	**27,337**	**29,429**	**21,501**	**21,510**	**43,011**
Expenditures by Category					
Other Operating Expenses	379	328	352	374	726
Payments To Individuals	5,526	5,679	5,043	5,036	10,079
Local Assistance	21,432	23,422	16,106	16,100	32,206
Total	**27,337**	**29,429**	**21,501**	**21,510**	**43,011**

Program Description

Continuing Care Management is the administrative component for the service areas funded by Continuing Care Grants. It also coordinates with Health Care Management on the Medicaid-funded Continuing Care Grant activities.

Program at a Glance

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

Population Served

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

Services Provided

Department of Human Services (DHS) staff administer programs and services that are used by over 350,000 Minnesotans. This work is accomplished by working with citizens, counties, legislators, grantees, other state agencies and providers.

In addition to the normal management functions, which apply to all people served, Continuing Care Management performs unique specialized activities

- direct constituent service:
  - ⇒ statewide regional service centers which help deaf, deafblind, and hard-of-hearing people access community resources and the human services system;
  - ⇒ the Equipment Distribution Program, which helps deaf and hard-of-hearing people access the telephone system with specialized equipment;
  - ⇒ HIV/AIDs programs which help people with HIV/AIDs obtain and maintain needed health care coverage; and
  - ⇒ ombudsman services for older Minnesotans which assist consumers in resolving complaints and preserving access to services;
- citizen/consumer feedback:

Staff assistance and administrative support are provided to a number of legislatively-required councils including

- The Minnesota Commission Serving Deaf and Hard of Hearing People;
- The Minnesota Board on Aging;
- The State Advisory Council on Mental Health;
- Alcohol and Other Drug Abuse Advisory Council;
- American Indian Advisory Council on Alcohol and Other Drug Abuse;
- Traumatic Brain Injury Service Integration Advisory Committee; and
- Long-term Care Advisory Committee;
- collaborative efforts with local partners and other state agencies; and
- special projects and responsibilities.

Historical Perspective

Years ago, most people needing publicly-funded services received them in institutions. Through the years, priorities, values, and expectations changed. Today, more choices are available, providing people with more individualized and better quality options.

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

- describing the demographic realities of the state's aging population and working with many constituencies to prepare responses to these profound changes;
- implementing strategies of the long-term care task force that reform Minnesota's long-term care system for the elderly. This includes administering the voluntary, planned closure of nursing facility beds and expanding

use of home and community-based services through grants and other mechanisms to develop community capacity;

- working with community partners that include the Citizen's League, Consumer Survivor's Network, the State Mental Health Advisory Councils, and the Department of Health to increase the public's understanding of our citizens' mental health needs and the community infrastructure, both formal and informal, that will meet those needs;
- taking actions necessary to increase flexibility, reduce access barriers, and promote consumer choice and control with the home care and waivered services covered by Medical Assistance;
- managing cost growth in home and community based waiver programs while reducing reliance on hospital and institutional care;
- working with consumers, family members, county agencies, provider organizations, and advocates to develop community options for younger persons with disabilities currently residing in institutional settings;
- developing the Minnesota Senior Health Options (MSHO) and Minnesota Disability Health Options (MDHO) projects that integrate health and long-term care for "dual eligible" elderly and younger persons with disabilities to improve community capacity;
- working with American Indian stakeholders to clarify desired outcomes of culturally appropriate substance abuse and mental health services necessary to address the needs of their people;
- working with members of the Ethiopian, Oromo, and Somali communities in Minnesota to obtain federal grant funds to improve the access of resettled refugees to mainstream continuing care services; and
- working with contract nursing homes under the Alternative Payment System to continually improve quality.

Key Measures

⇒ Proportion of nursing home days paid by funding source.
⇒ Proportion of elders served in institutional vs. community settings.
⇒ Proportion of public-funded long-term care funds expended in institutional vs. community settings.
⇒ Percent of persons with serious and persistent mental illness served in institutional settings.
⇒ Average days in an institutional setting per recipient with mental illness.
⇒ Percent of persons with serious and persistent mental illness readmitted to a hospital setting within 30 days of discharge.

More information on Department of Human Services measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Program Funding

Continuing Care Management is funded primarily with appropriations from the General Fund, State Government Special Revenue Fund, and Lottery Fund and from federal funds.

Contact

For more information on Continuing Care Management, contact

- Assistant Commissioner for Continuing Care Loren Colman, (651) 297-4155
- Assistant Commissioner for Chemical and Mental Health Services Wes Kooistra, (651) 296-6993
- Sue Banken, Fiscal & Legislative Operations, (651) 296-5724
- Don Allen (651) 297-5298

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	21,049	17,262	17,262	17,262	34,524
Technical Adjustments					
Current Law Base Change			(30)	(30)	(60)
Transfers Between Agencies			(3,043)	(3,043)	(6,086)
Subtotal - Forecast Base	21,049	17,262	14,189	14,189	28,378
Governor's Recommendations					
Medicare Modernization Act Changes		0	350	307	657
Total	**21,049**	**17,262**	**14,539**	**14,496**	**29,035**
State Government Spec Revenue					
Current Appropriation	119	119	119	119	238
Subtotal - Forecast Base	119	119	119	119	238
Total	**119**	**119**	**119**	**119**	**238**
Lottery Cash Flow					
Current Appropriation	148	148	148	148	296
Subtotal - Forecast Base	148	148	148	148	296
Total	**148**	**148**	**148**	**148**	**296**
Expenditures by Fund					
Direct Appropriations					
General	15,681	18,587	14,539	14,496	29,035
State Government Spec Revenue	71	167	119	119	238
Lottery Cash Flow	144	152	148	148	296
Statutory Appropriations					
Special Revenue	2,906	3,328	3,007	3,327	6,334
Federal	13,213	17,802	16,192	16,129	32,321
Miscellaneous Agency	0	300	300	300	600
Gift	11	20	8	8	16
Total	**32,026**	**40,356**	**34,313**	**34,527**	**68,840**
Expenditures by Category					
Total Compensation	17,146	18,832	18,496	18,704	37,200
Other Operating Expenses	14,880	21,524	15,817	15,823	31,640
Total	**32,026**	**40,356**	**34,313**	**34,527**	**68,840**
Expenditures by Activity					
Continuing Care Management	32,026	40,356	34,313	34,527	68,840
Total	**32,026**	**40,356**	**34,313**	**34,527**	**68,840**
Full-Time Equivalents (FTE)	**258.9**	**269.4**	**272.4**	**272.4**	

HUMAN SERVICES DEPT
Program: CONTINUING CARE MANAGEMENT
Activity: CONTINUING CARE MANAGEMENT

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	21,049	17,262	17,262	17,262	34,524
Technical Adjustments					
Current Law Base Change			(30)	(30)	(60)
Transfers Between Agencies			(3,043)	(3,043)	(6,086)
Subtotal - Forecast Base	21,049	17,262	14,189	14,189	28,378
Governor's Recommendations					
Medicare Modernization Act Changes		0	350	307	657
Total	**21,049**	**17,262**	**14,539**	**14,496**	**29,035**
State Government Spec Revenue					
Current Appropriation	119	119	119	119	238
Subtotal - Forecast Base	119	119	119	119	238
Total	**119**	**119**	**119**	**119**	**238**
Lottery Cash Flow					
Current Appropriation	148	148	148	148	296
Subtotal - Forecast Base	148	148	148	148	296
Total	**148**	**148**	**148**	**148**	**296**
Expenditures by Fund					
Direct Appropriations					
General	15,681	18,587	14,539	14,496	29,035
State Government Spec Revenue	71	167	119	119	238
Lottery Cash Flow	144	152	148	148	296
Statutory Appropriations					
Special Revenue	2,906	3,328	3,007	3,327	6,334
Federal	13,213	17,802	16,192	16,129	32,321
Miscellaneous Agency	0	300	300	300	600
Gift	11	20	8	8	16
Total	**32,026**	**40,356**	**34,313**	**34,527**	**68,840**
Expenditures by Category					
Total Compensation	17,146	18,832	18,496	18,704	37,200
Other Operating Expenses	14,880	21,524	15,817	15,823	31,640
Total	**32,026**	**40,356**	**34,313**	**34,527**	**68,840**
Full-Time Equivalents (FTE)	**258.9**	**269.4**	**272.4**	**272.4**	

Program Description

State Operated Services (SOS) provides direct care services to people with disabilities. These services are provided to clients by the Department of Human Services (DHS) at campus-based regional treatment centers (RTCs) and state-operated programs and residences located within communities. SOS also includes forensics programs at Moose Lake, St. Peter, and Cambridge.

Budget Activities Included:

⇒ Appropriated Services
⇒ Enterprise Services

HUMAN SERVICES DEPT

Program: STATE OPERATED SERVICES

Program Summary

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	195,062	187,224	187,224	187,224	374,448
Technical Adjustments					
Current Law Base Change			1,531	(5,716)	(4,185)
Subtotal - Forecast Base	195,062	187,224	188,755	181,508	370,263
Governor's Recommendations					
SOS Forensics Services Util.		0	17,731	19,797	37,528
Total	**195,062**	**187,224**	**206,486**	**201,305**	**407,791**
Expenditures by Fund					
Direct Appropriations					
General	186,613	209,061	206,486	201,305	407,791
Statutory Appropriations					
Special Revenue	9,412	10,186	7,452	6,895	14,347
Federal	114	116	116	116	232
Miscellaneous Agency	3,186	3,333	3,333	3,333	6,666
Gift	0	9	9	9	18
Endowment	1	1	1	1	2
Mn State Operated Comm Svcs	67,342	68,258	68,258	68,258	136,516
Mn Neurorehab Hospital Brainer	16,050	18,717	18,717	18,717	37,434
Dhs Chemical Dependency Servs	18,296	18,030	18,030	18,030	36,060
Total	**301,014**	**327,711**	**322,402**	**316,664**	**639,066**
Expenditures by Category					
Total Compensation	244,940	238,818	257,935	252,684	510,619
Other Operating Expenses	48,425	82,120	58,932	58,445	117,377
Payments To Individuals	4,683	5,121	5,120	5,120	10,240
Local Assistance	2,476	1,237	0	0	0
Other Financial Transactions	490	415	415	415	830
Total	**301,014**	**327,711**	**322,402**	**316,664**	**639,066**
Expenditures by Activity					
Appropriated Services	199,326	222,698	217,389	211,651	429,040
Enterprise Services	101,688	105,013	105,013	105,013	210,026
Total	**301,014**	**327,711**	**322,402**	**316,664**	**639,066**
Full-Time Equivalents (FTE)	**4,086.2**	**4,084.9**	**3,898.9**	**3,822.0**	

Activity Description

State Operated Services (SOS) Appropriated Services provides specialized treatment and related supports for people with disabilities who cannot otherwise access services in community settings. These services are provided in campus-based programs, community facilities, group homes, and through direct outreach services to people.

Activity at a Glance

- Provides inpatient services to approximately 3,200 people annually with an average daily population of 1,000
- Provides over 20,000 services annually to people in the community

Population Served

SOS Appropriated Services serve

- adults with mental illness who need inpatient and community-based services;
- elderly people who need nursing facility care;
- people with developmental disabilities who need services in the community;
- people with developmental disabilities who pose a public safety risk; and
- people who are committed mentally ill and dangerous or serious sex offenders.

Services Provided

Appropriated Services provides four sets of programs:

⇒ Adult Mental Health (MH) Services includes inpatient psychiatric services provided to adults with mental illness at the regional treatment center (RTC) campuses located in Anoka, Brainerd, Fergus Falls, St. Peter, and Willmar. In 2003, the legislature approved the extension of Adult MH Services into community-based settings, where services are delivered closer to an individual's home and personal support systems. These services are frequently provided in partnership with counties and other community service providers.

⇒ Nursing Facility (NF) Services are provided at the Ah-Gwah-Ching Center in Walker. This facility operates as a nursing home for clients referred from other parts of SOS and the Minnesota Department of Corrections.

⇒ Forensic Services includes three major program areas. The Minnesota Extended Treatment Option (METO) program is a specialized service for adults from across the state with developmental disabilities whose behaviors present a public safety risk. The focus of treatment in this program is on changing client behavior and identifying necessary supports that will permit them to return to the community.

The Minnesota Security Hospital (MSH), a facility located in St. Peter, provides multi-disciplinary forensic treatment services for people who are under civil commitment as mentally ill and dangerous. This facility serves adults from throughout the state who are admitted pursuant to judicial or other lawful orders for assessment and/or treatment of acute and chronic major mental disorders. MSH also provides comprehensive court-ordered forensic evaluations, including competency to stand trial and pre-sentence mental health evaluations. In addition, MSH operates a Forensic Transition program that provides a supervised residential setting offering social rehabilitation treatment to increase self-sufficiency and build the skills necessary for a safe return to the community.

Minnesota's third forensic program is the Minnesota Sex Offender Program (MSOP). This program includes facilities at sites in Moose Lake and St. Peter. People are referred to the sex offender program through the civil commitment process. The majority of people are referred from the Department of Corrections (DOC) upon completion of their sentences. The Department of Human Services (DHS) and DOC have collaborated to establish a uniform process for managing sex offenders and have established a partnership to provide sex offender treatment in the Moose Lake Correctional Facility.

⇒ Community Services for the developmentally disabled include community health clinics that provide psychiatric and/or dental services to people who are unable to obtain these services in the community and community support services in the form of technical assistance, staff training and education, crisis

intervention, direct staff support to families and providers, and crisis placement in community residences for people who must be removed from their existing residential setting.

Historical Perspective

Minnesota's public policy is based on providing treatment and supports for persons with disabilities in the community. As the community service infrastructure has developed, there has been a change in the utilization of the SOS system. The RTC developmental disabilities programs have closed and all clients are being served in community-based care. In 2003, the legislature adopted a proposal to expand community-based adult mental health programs. This has reduced the length of stay in the RTCs and has allowed clients to return to the community faster.

As the SOS RTC campus-based system has become smaller and more dispersed, administrative consolidation and simplification has occurred to make SOS more cost efficient.

Key Measures

⇒ Percent of persons with serious and persistent mental illness served in institutional settings.
⇒ Average days in an institutional setting per recipient with mental illness.
⇒ Percent of persons with serious and persistent mental illness readmitted to a hospital setting within 30 days of discharge.

More information on Department of Human Services measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

Appropriated Services is funded with appropriations from the General Fund.

Contact

For more information on SOS Services, contact

- Assistant Commissioner for Chemical and Mental Health Services Wes Kooistra, (651-6993
- Legislative and Fiscal Operations Manager Don Allen, (651) 297-5298
- State Operated Services Chief Executive Officer Mike Tessneer, (651) 582-1885
- State Operated Services Chief Operating Officer Fran Bly, (651) 582-1868

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: STATE OPERATED SERVICES
Activity: APPROPRIATED SERVICES

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Direct Appropriations by Fund					
General					
Current Appropriation	195,062	187,224	187,224	187,224	374,448
Technical Adjustments					
Current Law Base Change			1,531	(5,716)	(4,185)
Subtotal - Forecast Base	195,062	187,224	188,755	181,508	370,263
Governor's Recommendations					
SOS Forensics Services Util.		0	17,731	19,797	37,528
Total	**195,062**	**187,224**	**206,486**	**201,305**	**407,791**
Expenditures by Fund					
Direct Appropriations					
General	186,613	209,061	206,486	201,305	407,791
Statutory Appropriations					
Special Revenue	9,412	10,186	7,452	6,895	14,347
Federal	114	116	116	116	232
Miscellaneous Agency	3,186	3,333	3,333	3,333	6,666
Gift	0	1	1	1	2
Endowment	1	1	1	1	2
Total	**199,326**	**222,698**	**217,389**	**211,651**	**429,040**
Expenditures by Category					
Total Compensation	167,640	157,575	176,692	171,441	348,133
Other Operating Expenses	25,153	59,592	36,404	35,917	72,321
Payments To Individuals	4,026	4,294	4,293	4,293	8,586
Local Assistance	2,476	1,237	0	0	0
Other Financial Transactions	31	0	0	0	0
Total	**199,326**	**222,698**	**217,389**	**211,651**	**429,040**
Full-Time Equivalents (FTE)	**2,716.3**	**2,604.9**	**2,418.9**	**2,342.0**	

Activity Description

State Operated Services (SOS) Enterprise Services provides services to people with disabilities while operating in the marketplace with other providers. These services are funded solely through revenues collected from third-party payment sources.

Activity at a Glance

- Provides treatment for chemical abuse or dependency to 3,500 people
- Provides services to 325 people in community residential sites across Minnesota
- Provides day treatment and habilitation to 550 people with developmental disabilities
- Provides services to 15 to 20 clients with acquired brain injuries
- Provides treatment for emotional disturbances to approximately 300 children and adolescents

Population Served

Enterprise Services programs serve

- people with chemical abuse or dependency problems;
- people who are developmentally disabled (DD);
- people with acquired brain injuries; and
- children and adolescents with severe emotional disturbances.

Services Provided

Enterprise Services includes a variety of programs:

⇒ State operated chemical dependency (CD) programs provide inpatient and outpatient treatment to persons with chemical dependency and substance abuse problems. Programs are operated in Anoka, Brainerd, Carlton, Fergus Falls, St. Peter, and Willmar. Each CD program negotiates a host county contract that establishes the parameters of the services offered. Rates differ by program and type of services provided.

⇒ SOS community-based residential services for people with DD typically are provided in four-bed group homes. Individual service agreements are negotiated with the counties for each client based on his/her needs. Clients take advantage of and are integrated into the daily flow of their community.

⇒ Day Training and Habilitation (DT&H) programs provide vocational support services to people with DD and include evaluation, training, and supported employment. Individual service agreements are negotiated for each client.

⇒ The Minnesota Neurorehabilitation Hospital (MNH), located on the Brainerd Regional Human Services campus, provides intensive rehabilitation services to people with acquired brain injury who have challenging behaviors. The MNH is a 15-bed program serving the entire state of Minnesota.

⇒ Child and Adolescent Behavioral Health Services (CABHS) provides an array of services ranging from in-home crisis intervention to hospital care. CABHS does this with its own staff and by partnering with other caregivers and contracting with private providers. This is a statewide program providing hospital-level care in Brainerd and Willmar.

Historical Perspective

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

Key Measures

⇒ Proportion of public-funded long-term care funds expended in institutional vs. community settings.

More information on Department of Human Services (DHS) measures and results is available on the web: http://www.departmentresults.state.mn.us/hs/index.html.

Activity Funding

Enterprise Services is supported solely through collections from third party payment sources including

- Consolidated Chemical Dependency Treatment Fund;
- Medical Assistance;
- Medicare;
- commercial and private insurance; and
- individual or self-pay.

Contact

For more information on Enterprise Services, contact

- Assistant Commissioner for Chemical and Mental Health Services Wes Kooistra, (651) 296-6993
- Legislative and Fiscal Operations Manager Don Allen, (651) 297-5298
- State Operated Services Chief Executive Officer Mike Tessneer, (651) 582-1885
- State Operated Services Chief Operating Officer Fran Bly, (651) 582-1868

Information is also available on the DHS web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT

Program: STATE OPERATED SERVICES

Activity: ENTERPRISE SERVICES

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2004	FY2005	FY2006	FY2007	2006-07
Expenditures by Fund					
Statutory Appropriations					
Gift	0	8	8	8	16
Mn State Operated Comm Svcs	67,342	68,258	68,258	68,258	136,516
Mn Neurorehab Hospital Brainer	16,050	18,717	18,717	18,717	37,434
Dhs Chemical Dependency Servs	18,296	18,030	18,030	18,030	36,060
Total	**101,688**	**105,013**	**105,013**	**105,013**	**210,026**
Expenditures by Category					
Total Compensation	77,300	81,243	81,243	81,243	162,486
Other Operating Expenses	23,272	22,528	22,528	22,528	45,056
Payments To Individuals	657	827	827	827	1,654
Other Financial Transactions	459	415	415	415	830
Total	**101,688**	**105,013**	**105,013**	**105,013**	**210,026**
Full-Time Equivalents (FTE)	**1,369.9**	**1,480.0**	**1,480.0**	**1,480.0**	

Dollars in Thousands

	Actual FY2004	Budgeted FY2005	Governor's Recomm. FY2006	Governor's Recomm. FY2007	Biennium 2006-07
Non Dedicated Revenue:					
Departmental Earnings:					
General	46,476	55,400	71,604	77,886	149,490
Grants:					
General	0	0	19,814	19,996	39,810
Federal Tanf	261,032	274,124	289,567	286,959	576,526
Other Revenues:					
General	108,727	107,774	114,287	115,116	229,403
Health Care Access	3,695	2,980	4,886	4,397	9,283
Taxes:					
General	196,774	204,616	204,180	97,415	301,595
Health Care Access	0	0	0	112,878	112,878
Total Non-Dedicated Receipts	**616,704**	**644,894**	**704,338**	**714,647**	**1,418,985**
Dedicated Receipts:					
Departmental Earnings (Inter-Agency):					
Special Revenue	111	125	135	145	280
Departmental Earnings:					
General	3,426	3,171	3,236	3,309	6,545
Health Care Access	25,226	27,992	26,491	31,386	57,877
Special Revenue	9,597	10,287	8,755	8,518	17,273
Federal	15,781	15,651	18,389	18,888	37,277
Mn State Operated Comm Svcs	62,861	68,060	68,060	68,060	136,120
Mn Neurorehab Hospital Brainer	15,740	19,017	19,017	19,017	38,034
Dhs Chemical Dependency Servs	18,334	17,864	17,864	17,864	35,728
Grants:					
General	33,966	41,006	40,700	40,457	81,157
Special Revenue	30,505	32,682	32,933	34,459	67,392
Federal	3,699,653	3,717,511	3,880,025	4,052,992	7,933,017
Other Revenues:					
General	1,259	170	170	170	340
Health Care Access	54	0	0	0	0
Special Revenue	101,680	105,532	96,818	102,350	199,168
Federal	34,088	104	100	100	200
Miscellaneous Agency	603,810	630,852	630,750	630,749	1,261,499
Gift	19	70	69	69	138
Endowment	1	1	1	1	2
Mn State Operated Comm Svcs	362	881	881	881	1,762
Mn Neurorehab Hospital Brainer	58	51	51	51	102
Dhs Chemical Dependency Servs	59	60	60	60	120
Other Sources:					
Miscellaneous Agency	3,059	182,212	182,212	182,212	364,424
Total Dedicated Receipts	**4,659,649**	**4,873,299**	**5,026,717**	**5,211,738**	**10,238,455**
Agency Total Revenue	**5,276,353**	**5,518,193**	**5,731,055**	**5,926,385**	**11,657,440**

Dollars in Thousands

	Actual FY2004	Budgeted FY2005	Governor's Recomm. FY2006	Governor's Recomm. FY2007	Biennium 2006-07
Non Dedicated Revenue:					
Departmental Earnings:					
General	46,476	55,400	71,604	77,886	149,490
Grants:					
General	0	0	19,814	19,996	39,810
Federal Tanf	261,032	274,124	289,567	286,959	576,526
Other Revenues:					
General	108,727	107,774	114,287	115,116	229,403
Health Care Access	3,695	2,980	4,886	4,397	9,283
Taxes:					
General	196,774	204,616	204,180	97,415	301,595
Health Care Access	0	0	0	112,878	112,878
Total Non-Dedicated Receipts	**616,704**	**644,894**	**704,338**	**714,647**	**1,418,985**
Dedicated Receipts:					
Departmental Earnings (Inter-Agency):					
Special Revenue	111	125	135	145	280
Departmental Earnings:					
General	3,426	3,171	3,236	3,309	6,545
Health Care Access	25,226	27,992	26,491	31,386	57,877
Special Revenue	9,597	10,287	8,755	8,518	17,273
Federal	15,781	15,651	18,389	18,888	37,277
Mn State Operated Comm Svcs	62,861	68,060	68,060	68,060	136,120
Mn Neurorehab Hospital Brainer	15,740	19,017	19,017	19,017	38,034
Dhs Chemical Dependency Servs	18,334	17,864	17,864	17,864	35,728
Grants:					
General	33,966	41,006	40,700	40,457	81,157
Special Revenue	30,505	32,682	32,933	34,459	67,392
Federal	3,699,653	3,717,511	3,880,025	4,052,992	7,933,017
Other Revenues:					
General	1,259	170	170	170	340
Health Care Access	54	0	0	0	0
Special Revenue	101,680	105,532	96,818	102,350	199,168
Federal	34,088	104	100	100	200
Miscellaneous Agency	603,810	630,852	630,750	630,749	1,261,499
Gift	19	70	69	69	138
Endowment	1	1	1	1	2
Mn State Operated Comm Svcs	362	881	881	881	1,762
Mn Neurorehab Hospital Brainer	58	51	51	51	102
Dhs Chemical Dependency Servs	59	60	60	60	120
Other Sources:					
Miscellaneous Agency	3,059	182,212	182,212	182,212	364,424
Total Dedicated Receipts	**4,659,649**	**4,873,299**	**5,026,717**	**5,211,738**	**10,238,455**
Agency Total Revenue	**5,276,353**	**5,518,193**	**5,731,055**	**5,926,385**	**11,657,440**