Department of Human Services
FY18-19 Supplemental Budget Change Items
March 19, 2018
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Department of Human Services

FY18-19 Biennial Budget Change Item

Change Item Title: MinnesotaCare Buy-In Option for Individual Market (HC-40)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	0	0	58,391	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	2,691	(89,766)	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	2,691	(31,375)	0
FTEs	**0**	**0**	**92**	**0**

Request:

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

This proposal has a one-time cost to the Health Care Access Fund of $12.9 million spread across FY2019 and 2020. The proposal also repurposes $58 million in unused funds from the state's premium subsidy account and $42 million in funds unused by the Minnesota Comprehensive Health Association (MCHA) for purposes of establishing a program reserve.

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Proposal:

Under this proposal, DHS will develop a state-purchased product to be offered as an affordable alternative to consumers eligible to buy a qualified health plan on the individual market. This new product will be based on the MinnesotaCare program. It will be made available to consumers in the QHP market between November 2019 and January 2020 and any applicable enrollment periods thereafter. Coverage purchased during 2019 open enrollment would be effective for services provided on or after January 1, 2020. DHS will seek all necessary waivers, including authority under section 1332 of the Affordable Care Act (ACA), to implement this proposal.

This product will offer eligible consumers a similar benefit set and provider network as the standard MinnesotaCare program, which provides more robust coverage than the minimum requirements set forth under the ACA for the standard QHP product. Consumer premiums will reflect the full cost of care and administrative costs to operate the program. Two product levels will be offered equivalent to a silver- and a gold-level product in the QHP market. A silver level plan provides for a 70 percent actuarial value (AV) and a gold level plan provides for an 80 percent AV. This means that the plan would cover either 70 or 80 percent of a person's health care expenses for the year, respectively. As with the purchase of any qualified health plan, individuals eligible for advance federal premium tax credits subsidies will be able to apply this assistance to reduce the cost of the product. The projected statewide average premium for the buy-in option is $659 for a silver level product.

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

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

The proposal also repurposes $58 million in unused funds from the state's premium subsidy account and $42 million in funds unused by the Minnesota Comprehensive Health Association (MCHA) for purposes of establishing a program reserve to support cash-flow, coverage, claims and liabilities for the program. This would allow DHS to meet any cash flow deficiencies related to the timing of the receipt of federal funds or enrollee premium payments by DHS and the need to expend funds to cover for administrative and enrollee costs.

To address concerns about lower provider rates, this proposal also includes building into the consumer premium a rate increase for providers when compared to the current MinnesotaCare program today. For people seeking services through the buy-in product, the Governor proposes that the Department ensure that rates are no lower than Medicare rates for such services. This will not come at an additional cost to the Minnesota state taxpayer. It will be built into the premium charged to the consumer.

Rationale/Background:

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

Like many other states, Minnesota has been experiencing premium increases and a reduced number of participating carriers. Moreover, according to the 2017 Health Access Survey conducted by Minnesota Department of Health and University of Minnesota, the state experienced one of the largest, one-time increases in the rate of uninsured Minnesotans since 2001. The uninsured rate rose from 4.3 percent in 2015 to 6.3 percent in 2017, leaving approximately 349,000 people without health care coverage last year. The increase was significantly higher parts of rural Minnesota including portions of northwest and west central Minnesota where the uninsured rate exceeded 10 percent.

There are two main reasons, according to the 2017 Health Access Survey, for the substantial rise in the uninsured rate: first, a decline in Minnesotans with coverage offered by employers; and second, shrinking enrollment in the individual market of about 2 percentage points between 2015 and 2017. The survey also found that 53 percent of people who no longer had coverage in 2017 said they could either no longer afford to maintain it or that cost was a barrier to purchasing new coverage.

While the rate of uninsured increased across most demographic groups, the uninsured rate for people of color and American Indians residing in Minnesota saw especially large increases and is now three times higher than the uninsured rate for white residents. This option will provide more affordable options to all individuals impacted by recent changes in the individual market. Many people who are uninsured and underinsured fall within the racial and ethnic groups in Minnesota that experience significant disparities in health status and in rates of health insurance coverage. For this reason, this new buy-in option will likely decrease these disparities by increasing access to coverage that affordable and comprehensive.

The Governor is proposing that the Department of Human Services (DHS) offer an alternative for consumers purchasing health insurance in Minnesota's individual market who have limited options when it comes to affordable coverage. This alternative qualified health plan will be based on the success of the bipartisan MinnesotaCare program and its legacy in providing comprehensive and affordable coverage options for low-income Minnesotans over the last two decades. This includes maximizing and leveraging the state's purchasing power for its public health care programs in order to get better value for the consumer and the state.

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

and cost-sharing or providing additional benefits to enrollees eligible for BHP funding. Nothing in this proposal would change the state's authority to receive federal funds and to operate MinnesotaCare as a basic health program for people with incomes below 200 percent.

Administering the new product in MNsure like a QHP will require ongoing funding to support call center operations, establish and maintain benefit and eligibility policy, develop and manage the waiver processes and meet federal reporting requirements, establish new accounting processes and support ongoing financial operations, provide enrollee notices and communications, and support managed care rate setting and contracting processes. The fiscal detail table includes the first nine months of administrative funding needed to implement and administer this program and the costs of actuarial work for rate development for the 2020 plan year.

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

Function	FTEs	FY2019-20 Cost (thousands)
Member help desk and communications support	4	$329
Enrollee call center, recipient communications, and training staff	81	$6,907
Benefits policy, managed care contracting and enrollment support, claims and financial operations support	5	$595
Accounting and financial operations support	2	$166
Eligibility Policy Support	1	$87
Enrollee notices and postage costs		$1,500
Actuarial support for managed care rate setting		$650
Subtotal Business Functions	**92**	**10,234**
Systems		2,691
Total Proposal Cost		12,925

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

This estimate also assumes that, beginning in the third quarter of 2020 and thereafter, the consumer premiums and premium withhold funds collected under Minnesota Statutes 62V.05 will fund all ongoing costs necessary to manage the program and support ongoing maintenance of IT systems and operational and administrative functions. This includes any costs allocated to support operations related to offering this product in MNsure as a QHP.

IT Related Proposals:

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

Results:

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Uninsured rate	4.3%	6.3%	2015, 2017

Statutory Change(s):

Minnesota Statutes 256L.29

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund				0	0	58,391		58,391
HCAF				2,691	2,691	10,234	0	10,234
Federal TANF				0	0	0	0	0
Other Fund				0	0	(100,000)		(100,000)
Total All Funds				2,691	2,691	(31,375)	0	(31,375)
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF		Transfer to MNCARE Buy-in ResReserve		0	0	58,391		58,391
OTH		Transfer into MNCARE Buy-in Res from GF		0	0	(58,391)	0	(58,391)
OTH		Transfer into MNCARE Buy-in Reserve from Premium Security Account		0	0	(41,609)	0	(41,609)
HCAF	11	Systems		2,691	2,691	0	0	0
HCAF	13	HCA Admin (FTE)		0	0	8,084	0	8,084
HCAF	13	HCA Admin (Non FTE)		0	0	2,150	0	2,150
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
HCAF	**13**			**0**	**0**	92	0	0

Department of Human Services

FY18-19 Supplemental Budget Change Item

Change Item Title: Preventing Inappropriate Access to Controlled Substances (HC-55)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	0	204	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	183	183
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	204	183	183
FTEs	**0**	**2**	**2**	**2**

Request:

The Governor recommends expanding access to the Prescription Monitoring Program (PMP) by the Department of Human Services (DHS) in order to enforce existing state law that prohibits pharmacies from dispensing controlled substances for cash to Medical Assistance (MA) and MinnesotaCare enrollees. This is part of the Governor's package to address the opioid problem in the state.

Proposal:

This proposal would provide DHS the authority to implement a data sharing arrangement with the Board of Pharmacy in order to identify controlled prescriptions dispensed to MA and MinnesotaCare enrollees that were paid for in cash. This arrangement is needed to support program integrity and enforce existing state law.

This proposal adopts a successful, efficient PMP data-sharing model implemented by other Medicaid programs. Under this model, DHS transmits batch files containing enrollees and claims to the PMP vendor, which would match the claims to the prescriptions in the PMP. The vendor provides DHS with a list of prescriptions dispensed to MA and MinnesotaCare enrollees identified by data matches. DHS would then compare the verified PMP data with claims data to determine which payments were made with cash. Data transferred under this proposal would only be used for the purpose of the matching described. Access to the data would be used only as needed to enforce existing law.

The need for administering this program at this level beyond 2021 will be informed by baseline and trend data that will be gathered during the first four years of this project. DHS anticipates that cash dispensation will drop over time as a result of education and enforcement, which could allow DHS to move from monthly reviews to quarterly or semi-annual reviews. Once DHS has authority to implement this change, DHS staff will coordinate with the Board of Pharmacy to amend the Board's contract with the PMP vendor. Contractual changes would be in effect by fall 2018 and the data exchange would commence shortly thereafter.

Rationale/Background:

Both Minnesota statute and DHS policy prohibit pharmacies from accepting cash payment for controlled substance prescriptions dispensed to MHCP enrollees. DHS lacks the ability to enforce this prohibition because it receives only claims and medical encounter data for prescriptions reimbursed by DHS fee-for-service or managed care. Some patients with opioid use disorder or other substance use disorders use "doctor shopping" and cash payment for prescriptions as a mechanism to obtain an unsafe quantity of prescription drugs.

The only data source that collects information about cash payment for controlled substance prescriptions is the Board of Pharmacy-administered Prescription Monitoring Program (PMP). DHS' current access to the PMP is limited to investigations by the Office of Inspector General pertaining to the restricted recipients program and to monitoring access to controlled substances by recipients enrolled in opioid treatment programs.

DHS has encountered instances of pharmacies accepting cash payments for controlled substances during the course of investigating individual recipients' eligibility for the restricted recipients program. However, there is currently no consistent mechanism for identifying when controlled substances are being purchased for cash by MHCP enrollees.

This proposal complements the work of both executive and judicial branches of state government (coordinated through the State Substance Abuse Strategy Executive Sponsors and the State Opioid Oversight Project) to address the prescription opioid epidemic. The gap that prevents enforcement of existing state law against dispensing controlled substances for cash to MHCP recipients is stark. It threatens program integrity and also the health of MHCP recipients who could be exposed to dangerously high quantities of opioids.

Fiscal Impact:

This proposal expands the duties of the current PMP vendor under contract with the Board of Pharmacy. The cost to expand the scope of work is included in the fiscal detail below. An Opioid Stewardship Fund will be created within the State Government Special Revenue Fund. Revenue from the opioid stewardship fee will be deposited in the Opioid Stewardship Fund. Funding is appropriated from the Opioid Stewardship Fund for this activity. Funding for FY19 is appropriated from the General Fund.

The proposal also requests two FTEs in the Financial Fraud and Abuse Investigations Division – one nurse investigator and one data analyst. The nurse investigator is needed to review claims data related to the MHCP recipients and pharmacies identified in the contractor's report. The data analyst is needed to provide data analysis of patterns found in the recipient medical claims and provider billing information.

IT Related Proposals:

This proposal includes batch transfer of existing claims and encounter data to the PMP vendor. No systems changes should be needed.

Results:

DHS will capture a new data point—controlled substances dispensed for cash to MHCP recipients—and using existing demographic data, identify total prescriptions dispensed for cash and any demographic disparities in cash dispensation.

DHS will use the data to educate providers and outreach to patients with substance use disorder. Enrolled dispensing providers accepting cash in violation of statute could be subject to a stipulated provider agreement or ultimately termination from the program. Trend data over time will be used to assess whether education and enforcement activities are reducing cash dispensation consistent with state law.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Results	Instances of MA recipients paying cash for pharmacy dispensed controlled substances	N/A	N/A	N/A

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund				204	204	0	0	0
HCAF								
Federal TANF								
Other Fund				0	0	183	183	366
Total All Funds				204	204	183	183	366
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	13	HCA Admin (Contract)		50	50	0	0	0
GF	11	FFIAD Admin (2.0 FTE)		264	264	0	0	0
GF	REV1	FFP @ 35%		(110)	(110)	0	0	0
OTH	13	HCA Admin (Contract)		0	0	24	24	48
OTH	11	FFIAD Admin (2.0 FTE)		0	0	258	258	516
OTH	REV1	FFP @ 35%		0	0	(99)	(99)	(198)
		Requested FTE's						

		FFIAD Admin		**2.0**		**2.0**	**2.0**	

Department of Human Services

FY18-19 Supplemental Budget Change Item

Change Item Title: Increasing Timely Access to Substance Use Disorder Treatment (CS-45)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	0	8	8	14
Revenues	0	0	(8)	(14)
Other Funds				
Expenditures	0	0	8	14
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	8	8	14
• **FTEs**	**0**	**0**	**0**	**0**

Request:

Effective July 1, 2019, the Governor recommends allowing the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT), a screening tool to identify individuals in need of substance use disorder care, to authorize a limited number of substance use disorder treatment services in order facilitate more timely access to care. This is part of the Governor's package to address the opioid problem in the state.

Proposal:

This proposal seeks to address the opioid crisis in Minnesota by facilitating timely access to high-quality, evidence-based care for people with opioid use disorders and other substance use disorders. Specifically, this proposal would expedite access to substance use disorder treatment services by the Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening tool to establish medical necessity for treatment services, while a comprehensive assessment of a person's needs is underway.

The SBIRT tool would be able to establish medical necessity for a combination of two hours of counseling sessions (group or individual), two episodes of peer support, and two episodes of service coordination. Any additional services would require a comprehensive assessment and an authorization for treatment. This will provide the opportunity for same day approval and access to initial substance use disorder services. The use of screening tools to authorize a limited number of treatment services would be effective July 1, 2019, subject to federal approval.

SBIRT can be completed in any appropriate setting, such as a primary care clinic, school, or correctional setting. SBIRT can be administered by a licensed alcohol and drug counselor or physician but can also be administered by a broader range of professionals, such as community health workers. Upon engagement with a treatment program, a more comprehensive assessment would be required to inform treatment needs for the client going forward, including the approval of any treatment services beyond those initially approved based on the screen. This use of SBIRT will provide an essential tool to help identify substance use disorder in a person early, address the delays in referral to treatment, and provide support to ensure an easier transition to treatment when clients are most vulnerable.

Rationale/Background:

The 2017 legislature approved a package of reforms to modernize Minnesota's system of substance use disorder care. A key element of this reform was streamlining the process for accessing SUD treatment by permitting an individual to go directly to a service provider to receive an assessment for SUD treatment services rather than needing a referral from a county, tribe, or managed care organization. This change will be phased in starting in July 2018. While this was an important step forward, there is still more that can be done to ensure people can access treatment in a timely fashion.

The use of SBIRT has the potential to expedite access to services as well as provide interim treatment and support for individuals waiting for an opening for more long-term and intensive treatment. SBIRT is currently available as a billable service under Medical Assistance and MinnesotaCare but its use is limited, in part because it can only be used to identify someone in need of substance use disorder service, not to authorize any treatment services to be delivered. Providing a mechanism to deliver, and bill for, an immediate treatment intervention through the use of SBIRT is intended to expedite the process by which an individual may receive treatment. With SBIRT, an individual could be connected with initial services the same day or shortly thereafter.

Fiscal Impact:

Providers are currently able to bill for conducting the SBIRT but not currently able to authorize treatment services. This proposal assumes that more people will use the SBIRT assessment if it can be used to authorize services, which will result in additional cost to the state. A positive SBIRT assessment, would authorize eligibility for the following:

- two units of peer supports,
- two units of care coordination, and
- two units of individual or group treatment sessions

There is no additional cost associated with these services, since the assumption is a brief shift in timing only. The payment rates for providing SBIRT for 15-30 minutes is $25.03, and the rate for more than 30 minutes is $49.56. The anticipated growth in use of the SBIRT is assumed to be modest initially based on current usage and to steadily increase in FY21 as an alternative to the Rule 25 assessment which will sunset as a result of the Substance Use Disorder Reform legislation passed in 2017.

This proposal is expected to increase access to Medicaid reimbursable assessment services, which will result in increased state expenditures as indicated in the table below. The state share of the cost of these additional services paid through the Medicaid (MA) would be $5,625 in FY2019, $7,875 in FY 2020 and $13,500 in FY 2021.

	FY 2018	FY 2019	FY 2020	FY 2021
Additional SBIRT Assessments		500	700	1200
Average Cost of Assessments		37.5	37.5	37.5
Total MA Cost		18,750	26,250	45,000
Federal share @ 70% (assumes 50% of cost for adults with no kids)		13,125	18,375	31,500
State share	**BACT 33**	5,625	7,875	13,500

An Opioid Stewardship Fund will be created within the State Government Special Revenue Fund. Revenue from the opioid stewardship fee will be deposited in the Opioid Stewardship Fund. Funding from the Opioid Stewardship Fund is transferred to the General Fund for this activity beginning in FY20. Funding for FY19 is appropriated from the General Fund.

IT Related Proposals:

Changes to the MMIS system are necessary to be able to identify when an individual screened positive by SBIRT is authorized for the initial, limited quantity, set of services.

Hours: *BA*	*Technical*	*QA / RM*	*PM*	*Total*	
10	*40*	*27*	*0*	*77*	***Total Hours***
Hourly Rate:					
$611.90	*$3,350.00*	*$1,785.78*	*$0.00*	*$5,747.68*	***Total Personnel Costs***

State share @29% = $1,667

Results:

- Decreased wait time to accessing treatment
- Increased number of people accessing treatment

Statutory Change(s):

254B, 256B

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund				8	8	0	0	0
HCAF								
Federal TANF								
Other Fund				0	0	8	14	22
Total All Funds				**8**	**8**	**8**	**14**	**22**
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
OTH	TOUT	Opioid Stewardship transfer to GF		0	0	8	14	22
GF	TIN	Transfer to GF		0	0	(8)	(14)	(22)
GF	33	Medical Assistance		6	6	8	14	22
GF	11	MMIS System Changes (@29%)		2	2	0	0	0
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Department of Human Services

FY18-19 Supplemental Budget Change Item

Change Item Title: Supporting Integrated Local Responses to the Opioid Crisis (CS-47)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	0	2,089	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	2,099	2,099
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	2,089	2,099	2,099
FTEs	**0**	**1.5**	**1.5**	**1.5**

Request:

Effective July 1, 2018, the Governor recommends providing $2 million in annual grant funding to support local communities to design and implement integrated and collaborative community responses to Minnesota's opioid crisis. This work would be supported by the use of tools and strategies that have proven effective and which bring together health care, social services, law enforcement, education and other stakeholders to address the impact of the opioid crisis on their community. This is part of the Governor's package to address the opioid problem in the state.

Proposal:

This proposal seeks to support locally-coordinated responses to the opioid crisis by providing grant funding to communities to develop and implement community-wide initiatives. Specifically, this proposal would provide $2 million in annual grant funding for communities to design and implement integrated responses to the opioid crisis utilizing a standardized tool that has shown to be effective. The community integration tool would be tailored to each community based on input from and collaboration with community partners in the areas each grant is intended to serve. The grant funding would provide communities with the resources needed to organize local efforts.

Grant funds will support coordination of local infrastructure. Grantees will be expected to match their request for state funding with local in-kind or fiscal support. With such local matches, grants averaging $100,000 annually for four years will be sufficient to support infrastructure coordination. Potential grantees include tribal and local governments, health care, behavioral health and addiction treatment providers and nonprofit social service and cultural agencies. Grantees will serve as fiscal agents for the multiple partners and will use the funding to hire project staff.

Grantees will be asked to identify where they and their partners are currently on an integration continuum. They will be expected to move to a higher level of integration during the course of the grant. The continuum breaks down as follows:

- Level A - Beginning: Know each other and can call as needed; may include only a single organization with informal partnerships with other sectors
- Level B - Progressing; informal or formal arrangements among at least three independent organizations and at least two sectors; may include data sharing agreements
- Level C - Intermediate: Mixture of formal and informal arrangements across at least three sectors; includes decision-making, resource-allocation, data sharing
- Level D - Advanced: Clearly documented roles, relationships, responsibilities; ongoing, regular meetings supported by resources and formal partnerships across 4 or more sectors; has to include sustainability and funding commitments; These arrangements include decision-making, shared governance, data-sharing, and some shared financial arrangements.

Grantees will also be asked to address one or more domains of the opioid crisis that are most relevant to them. The domains from which they can choose are:

- **Optimal chronic pain management** including treatment for people at high risk of opioid dependence (co-occurring mental health conditions; history of substance use disorder, etc.). Treatment should include culturally grounded approaches relevant to individual patients. Providers who treat chronic pain with opioids should have relevant partnerships in the community to reduce diversion of prescribed drugs (e.g., relationships with local law enforcement) and to identify and treat opioid use disorder (e.g., relationships with behavioral health and addiction treatment providers).

- **Treatment and recovery from opioid use disorder – Pregnant Women** requires a plan of safe care for mothers and babies that addresses medical, child welfare, substance use, and community support aspects to treatment and recovery. This proposal focuses on integration between child welfare and health care to integrate:

    - high quality pre- and post-natal medical and behavioral health care

    - plans of safe care by local child welfare agencies

    - individual family plan implementation/case management including a supervised peer recovery specialist or community health worker

    - hospital discharge planning processes aligned with plan of safe care

    - family home visiting services from local public health, if accepted by the client

    - community organizations that provide family and/or cultural support as needed into plans of safe care

    - Partners would include child welfare agencies, birthing hospitals and other health care providers, behavioral health and substance use disorder treatment providers, local public health agencies, and local nonprofit or cultural groups, including tribes.

- **Treatment and recovery from opioid use disorder – justice involved populations** supports initiation of medication assisted therapy (MAT) among people who are in jail and continuation MAT after release and provision of other treatment post-release. It supports continuation of care and prompt enrollment in health care coverage after release from prison among people who have started treatment in prison. It also encourages diversion of people convicted of drug-related offenses to treatment rather than punitive responses. Partners include local jail and prison officials and medical, behavioral health and addiction treatment providers, county social service agencies and drug courts

- **Treatment and recovery from opioid use disorder – all other populations:** This supports local capacity-building for the integration among substance use disorder treatment providers, mental health providers and MAT prescribers. It would support initiation of MAT in emergency department and detox settings. It also includes support for coordinated chronic treatment and recovery services after more intensive services are provided. Clear identification of roles and hand-offs as a client moves from one type of service setting to another is essential. Partners include child welfare or vulnerable adult agencies (when such family members are involved), health care providers (including emergency departments), substance use disorder and mental health treatment providers (including detox), local public health agencies, and local nonprofit or cultural groups, including tribes.

This proposal builds on a successful model and tool developed by DHS under the State Innovation Model initiative to promote effective, well-coordinated, local systems to respond to the opioid crisis. The tool supports communities to create clear standards and expected processes for local organizational structures (health care, law enforcement, child protection) to use in designing effective and sustainable responses to address the opioid crisis. For example, this tool would lay out the expectation for child welfare involvement in post hospital care of infants and mothers. These expectations would be then used to improve the uniformity of the processes (e.g. case planning before or soon after delivery) and the governance/ structure of these relationships (e.g. expectations for joint local process planning). These types of integration steps have shown success in mitigating the impact of the opioid crisis in communities like Little Falls.

Rationale/Background:

In 2016, opioid involved deaths continued to increase for Minnesotans. There was a 12% increase in opioid involved deaths from 2015 to 2016. The greatest number of opioid involved deaths continues to be due to commonly prescribed opioids; there were 186 prescription opioid overdose deaths in 2016. The number of drug overdose deaths that involved other opioids and methadone (i.e.

typically prescribed opioids, such as codeine, oxycodone, or hydrocodone) has remained stable over the past three years. Since 2010, heroin deaths have increased rapidly; there were 142 heroin involved deaths in 2016 or a 25% increase in heroin-involved overdose deaths from 2015. Other synthetic opioids (e.g. fentanyl, fentanyl analogs, tramadol) have increased nearly 80% since 2015; there were 96 synthetic opioid involved deaths in 2016. Of the 96 synthetic opioid involved deaths, 85 had fentanyl listed on the death certificate as a cause of death.

In the seven county metro area, all drug categories of overdose deaths increased, some dramatically, from 2015 to 2016. In the metro area, opioid deaths increased significantly, driven by a sharp increase in heroin and other synthetic opioid involved deaths. Other opioids and methadone increased 20%; heroin-involved deaths increased 41%; benzodiazepine and psychostimulant-involved deaths increased 48%; and other synthetic opioid-involved deaths increased 142%.

In greater Minnesota, different patterns emerge when examining drug overdose deaths. Other opioid and methadone-involved deaths decreased 14% from 2015, while heroin, synthetic opioid, and benzodiazepine-involved deaths all remained relatively stable from 2015. However, psychostimulant-involved (e.g. methamphetamine) deaths increased nearly 60% from 2015 to 2016 in greater Minnesota. There were 62 methamphetamine involved deaths in 2016 in greater Minnesota.

Minnesota is currently employing multiple strategies to address the opioid crisis at the state level, and with the Legislature's and Governor's support, success has been achieved in coordinating activities among state agencies and with the judicial branch. However, with only isolated exceptions around the state, there is a lack of integration and coordination at the local level among the many sectors that touch the opioid crisis: health care, law enforcement/public safety, child protection, education, drug/family courts and overlapping tribal and county jurisdictions. While some of these barriers have been tackled successfully, much more work is needed. Integration and collaboration at the local level is key to successfully addressing the opioid crisis and this proposal offers a structure to promote such efforts. Coordination at the local level, where real, measureable success is most needed, is, at best, uneven. Without functional local partnerships that cross health care, law enforcement, corrections/jails, addiction treatment, schools, social services and child welfare sectors, the response to the opioid crisis will remain needlessly disjointed.

Fiscal Impact:

This proposal requests $2,000,000 annually in grant funding for four years, beginning in FY19 and ending in FY22, to support 20 community integration grants of $100,000 each. In addition, the proposal includes 1.5 FTEs in the Health Care Administration for grant management and community integration technical and policy support.

An Opioid Stewardship Fund will be created within the State Government Special Revenue Fund. Revenue from the opioid stewardship fee will be deposited in the Opioid Stewardship Fund. Funding is appropriated from the Opioid Stewardship Fund for this activity beginning in FY20. Funding for FY19 is appropriated from the General Fund.

IT Related Proposals:

This proposal does not have an IT impact.

Results:

Each of the integration components proposed in this effort would have unique health outcome measures (e.g. integration of law enforcement and chronic prescribing would be measured by decreased incarceration and increased drug treatment for people convicted of drug-related offenses; decrease in drug-related crime; reduced numbers of new chronic users). These measures could be organized into a composite dashboard of community progress similar to the MDH opioid dashboard, but at a more localized level.

This proposal is intended to effectively develop local infrastructure to accomplish an end to the opioid crisis. To that end, a component of the proposal is the development and implementation of an integration standards tool for communities to score their status on specific components. The grid below would then be used to judge progress on each component area. The result of advancing any component will be a health improvement (e.g. improved communication between law enforcement and prescribers would result in a decrease in diversion of prescription drugs for illicit purposes).

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Rate of placement of newborns born with neonatal abstinence syndrome with birth mother;			

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
	Effective housing of individuals with opioid use disorder			
Quality	Community integration measures, such as: regular interactions among law enforcement, pharmacy and prescribers; Jail release planning to include medication assisted treatment plans			
Results	Decrease in out of home placements for newborns; Decrease in numbers of chronic users and drug diversions; Decrease in number of adolescents using opioids for non-indicated purposes; Decrease in jail recidivism			

Data will be collected from existing sources and specified by state agencies. Data about infrastructure progress will be collected semiannually by assessing progress on the integration standards tool.

Statutory Change(s): Uncodified, Rider

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
General Fund				2,089	2,089	0	0	0
HCAF								
Federal TANF								
Other Fund				0	0	2,099	2,099	4,198
Total All Funds				2,089	2,089	2,099	2,099	4,198
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	51	Health Care Grants		2,000	2,000	0	0	0
GF	13	HCA staff – (FTE - 0, 1.5, 0, 0)		137	137	0	0	0
GF	Rev1	FFP @ 35%		(48)	(48)	0	0	0
OTH	51	Health Care Grants		0	0	2,000	2,000	4,000
OTH	13	HCA staff – (FTE - 0, 0, 1.5, 1.5)		0	0	153	153	306
OTH	Rev1	FFP @ 35%		0	0	(54)	(54)	(108)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
	13	HCA – 9 mo. FY19		1.5		1.5	1.5	

Department of Human Services

FY18-19 Biennial Budget Change Item

Change Item Title: Strengthen Vulnerable Adult Protections (CC-42)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	289	6,583	7,361	7,312
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	289	6,583	7,361	7,312
FTEs	**0**	**23**	**23**	**22**

Request: The Governor recommends a strengthening of protections and rights for older and vulnerable adults and an investment of $6.872 million in FY 2018-19 and $14.673 million in FY 2020-21 to provide additional resources that are critical to enforcing laws to ensure that older and vulnerable adults receive high quality care, are protected from harm and have the right to live in dignity. This is part of a comprehensive package of proposals from the Governor based on the report *Addressing Elder Abuse in Minnesota Long-Term Care Settings* developed by the consumer workgroup formed by the Governor.

Proposal:

Effective July 1, 2018, the Governor recommends actions to:

1. Strengthen and Expand Rights of Older and Vulnerable Adults and Their Families

Recommendation: Currently, staff of the Office of Ombudsman for Long-Term Care are unable to fully meet the demand for their services. We recommend the addition of ten full-time equivalents (FTEs), including a full-time Deputy Ombudsman, 6 full-time regional ombudsmen, 2 full-time policy leads, and 1 full-time volunteer coordinator.

The Office of Ombudsman for Long-Term Care is a program of the Minnesota Board on Aging. The Office advocates for person-directed living, throughout the health care continuum, which respects individual values and preferences and preserves individual rights. Regional ombudsmen and volunteers work with consumers, citizens, nursing homes, hospitals, home care and social service agencies and public agencies to enhance the quality of life and services for individuals receiving health care and supportive services. The ombudsman staff act as independent consumer advocates who investigate complaints concerning the health, safety, welfare and rights of long-term care consumers, work to resolve individual concerns, and identify problems and advocate for changes to address them, at no charge to the consumer. Ombudsmen also offer information and consultation about nursing home, boarding care home, housing with services, assisted living, customized living, home care and hospital services, rights and regulations. Additionally, ombudsmen work with providers of long-term care services to promote a culture of person-directed living. As such, the Office is a resource for both seniors, families and providers who can help educate regarding the rights of adults using long-term care services and intervene before concerning situations get out-of-hand. These staff address a number of the recommendations from the report, *Addressing Elder Abuse in Minnesota Long-Term Care Settings,* related to clarifying the use of cameras and electronic monitoring devices in rooms, protecting clients from retaliation, protecting and expanding resident rights, providing information about health laws, new assisted living licensure, and increased protections in housing with services and assisted living.

Recommendation: Restructure appeal process rights of vulnerable adults or interested parties following administrative reconsideration to match those afforded an alleged perpetrator.

Currently a vulnerable adult or guardian, if any, has the right to request a reconsideration of the maltreatment determination if the person disagrees with the DHS investigative decision. If the party still disagrees they can ask the Vulnerable Adult Maltreatment Review Panel to review the determination and recommend another outcome to the lead investigative agency. The Consumer Workgroup has recommended that the vulnerable adult/guardian have the right to request a fair hearing. This will create a new, more formal hearing process to review a finding of "maltreatment not determined/inconclusive."

Under state statute, DHS Human Services judges hear vulnerable adult maltreatment cases. The purpose of the human services fair hearing process is to review agency determinations to make sure they comply with the law. This is done by conducting evidentiary hearings in which the facts are reviewed, and then the governing law is applied to those facts to reach decisions. Due to the subject matter, vulnerable adult maltreatment cases are some of the most complicated and labor intensive cases human services judges hear. We estimate it will require 6 FTE to manage the anticipated additional appeals case load associated with this proposal including 5 human services judges and 1 support staff.

Additional appeals hearings also require attendance by licensing investigative staff who are required to attend hearings to explain their decision, pulling them out of the field and legal unit staff to assist their preparation for the hearings. We anticipate 1 additional FTE is needed to staff this function across the Division.

2. Improve Licensing Regulation, Enforcement and Investigative Process, and MAARC Reporting

Recommendation: Increase the capacity of the Minnesota Adult Abuse Reporting Center (MAARC) to serve as the single point of entry for reports of abuse or neglect from settings currently reporting to the Minnesota Department of Health and to meet federally required timelines for transmission of these reports to investigating agencies.

To expand MAARC operations to include receiving reports from federally licensed facilities, this proposal funds additional staffing and IT support for the increased report volume. Federally licensed facilities, such as nursing homes, currently report suspected maltreatment of vulnerable adults using a Minnesota Department of Health (MDH) website, and to MAARC. Centers of Medicare and Medicaid (CMS) are requiring modifications to MAARC operations to meet federal requirements permitting nursing homes and other federally licensed facilities to report to MAARC and eliminate duplicate reporting to MDH. If MAARC is unable to meet these requirements nursing homes and other federally licensed facilities will continue to be required to report to MDH and MAARC.

MAARC operates 24/7 under DHS through a vendor contract. The contract requires the vendor to make report referrals to lead investigative agencies within 4 hours. CMS regulations for nursing facilities require a 2 hour maximum turn around on report referrals. The call center contract is increased by $1.4 million (before federal financial participation) in fiscal year 2019 with increases each year due to additional call volume and service costs. Of the overall increase, $560,000 annually is for vendor staffing for MAARC to meet CMS' two hour referral requirement. The total increase in fiscal year 2021 is $1.587 million.

The current MAARC budget does not have funding for 24/7 MN.IT support to resolve system or application service interruptions or failure. MN.IT support is required to meet CMS requirements to allow nursing homes and other federally licensed facilities to report to MAARC.

Recommendation: Automate and improve the timeliness of the Minnesota Adult Abuse Reporting Center (MAARC) notification to law enforcement for reports of apparent criminal behavior.

The Minnesota Adult Abuse Reporting Center (MAARC) is the statewide common entry point for both the public and mandated reporters to report suspected abuse, neglect or financial exploitation of a vulnerable adult. MAARC is statutorily required to notify law enforcement immediately when a report received may also be a criminal offense. Law enforcement, as mandated reporters, are also required to make a MAARC report when they discover suspected maltreatment of a vulnerable adult. Civil lead investigative agencies (Minnesota Department of Human Services, Minnesota Department of Health and counties) are responsible to respond to reports, make investigation decisions and protect vulnerable adults. Law enforcement and civil agencies are required to coordinate criminal and civil investigations. MAARC referrals inform law enforcement and the civil agency of their counterpart for investigation coordination and protection of the vulnerable adult.

MAARC notification to law enforcement is currently made by secure email PDF file. Unfortunately, law enforcement agencies are not able to convert the PDF file directly into their own systems and must manually enter report data into their own systems. Likewise, law enforcement agencies making mandated reports are not able to use their system's data for report entry in MAARC.

This proposal is for programming changes to allow: 1) MAARC's timely identification of the law enforcement agency with jurisdiction using mapping technology available in other state systems; 2) notifications to law enforcement made in a format allowing them to input the civil report directly into the agency's data system; and, 3) entry of mandated reports by law enforcement into MAARC using their data systems. Identification of the correct law enforcement agency with jurisdiction for a report is done based on address, city and location as well as interagency agreements. Currently, MAARC lacks technology to identify the agency with jurisdiction based on these elements and must use a paper process. Law enforcement agencies must coordinate when the address of the alleged incident is not consistent with the agency's jurisdiction. Civil lead investigative agencies are not aware of law enforcement agency changes following MAARC report referral, which in turn leads to delays in reestablishing communications between the relevant agencies.

Recommendation: Expand DHS Licensing capacity in order to meet the anticipated increase in reports and to facilitate increased communication between investigators, family members and other interested parties.

When initial maltreatment reports are received, each report receives an in-office investigation. Many of the reports do not include adequate information for the Division to determine the harm, or risk of harm, presented to the vulnerable adult or child by the reported events or conditions, or whether the issue reported represents maltreatment or a licensing violation. Intake staff complete research on the alleged perpetrator, alleged victim, and facility to check for duplicate or similar allegations. Staff then launch the report into an electronic workflow and our internal Division database. Intake staff identify and flag reports that have high priority needs and jurisdiction issues, and complete an initial triage for emergency protection needs. Each report involving the death of a vulnerable adult or child is immediately assigned for initial investigation. If the initial investigation shows that there may be maltreatment, then that report is immediately assigned for an out-of-office maltreatment investigation. For reports involving possible licensing violations, the report may be assigned to a licensing unit for an out-of-office investigation related to licensing standards instead of, or in addition to, a maltreatment investigation. The intake process is also the first step in identifying reports that need to be immediately assigned, need coordination with county emergency protection agencies and law enforcement, or need referral to another lead agency. Once the initial triage has been completed, the intake staff move the reports to the assessor staff for further review.

With the proposed changes, the lead investigative agency would now be required to provide the information to the vulnerable adult or the vulnerable adult's interested person, if known, within five days of receipt of the report, including: (1) the nature of the maltreatment allegations, including the report of maltreatment as allowed under law; (2) the name of the facility or other location at which alleged maltreatment occurred; (3) the name of the alleged perpetrator if the lead investigative agency believes disclosure of such information is necessary to protect the vulnerable adult; (4) protective measures that may be recommended or taken as a result of the maltreatment report; (5) the contact information for the investigator, or other information as requested and allowed under law; and (6) confirmation of whether the facility is investigating the matter and, if so: (i) an explanation of the process and estimated timeline of the investigation; and (ii) a statement that the lead investigative agency will provide an update on the investigation approximately every three weeks, upon request, and a report when the investigation is concluded. These additional notice requirements greatly expand what is in current law and would significantly impact current staff's ability to triage and assess reports without additional staff. We estimate that 5 additional licensing staff would be required inorder to meet the increased expectation of communication with family members and other interested parties.

Recommendation: Strengthen county vulnerable adult investigative capacity.

This proposal creates a state investment dedicated for county adult protective services through a vulnerable adult (VA) specific grant program. The grant allocation would be required to be used for the investigation of, and protection for, maltreated vulnerable adults who are the subjects of reports of suspected abuse, neglect or financial exploitation made to the Minnesota Adult Abuse Reporting Center (MAARC). This allocation will be the only state funding specifically dedicated to responding to MAARC reports. The allocation will incent conducting investigations and providing adult protective services for vulnerable adults who are the subject of suspected maltreated reports.

3. New Licensing Frameworks for Assisted Living and Dementia Care Across Residential Settings

Recommendation: Ensure adequate collaboration between DHS and MDH during the stakeholder process to develop an Assisted Living licensure framework.

One FTE is needed to collaborate with Minnesota Department of Health staff and work closely with the Ombudsman for Long-Term Care to facilitate the stakeholder process and engagement.

Rationale/Background: The Department has a critical interest in ensuring that vulnerable adults receive high quality care, are protected from harm and have the right to live in dignity. The state and federal government make a significant investment in services for older and vulnerable adults in Minnesota. In FY 2018, state and federal payments for MA long-term care facilities and long-term care waivers and home care totaled $4.917 billion. The Department of Human Services (DHS) is also responsible for conducting investigations and taking enforcement actions under the vulnerable adults act and for licensing various services provided to vulnerable adults.

Gaps and inequalities exist in current laws designed to safeguard Minnesota's older and vulnerable adults from abuse and provide other vital consumer rights. These gaps exist despite the fact that there are many laws already on the books designed to protect older and vulnerable adults—including, but not limited to the Heath Care Bill of Rights, the Home Care Bill of Rights, and the Minnesota Vulnerable Adults Act.

This proposal will put in place resources and policies to ensure that older and vulnerable adult rights are protected, ensure that allegations are investigated in a timely manner, and ensure that the system for reporting allegations of maltreatment and abuse is responsive to the needs of older and vulnerable adults and their families.

Fiscal Impact:

Office of Ombudsman for Long Term Care:

The proposal will require 10 FTEs to manage the additional requirements noted in the budget proposal. The FTEs are as follows: 6 client advocates to receive, investigate and work to resolve additional complaints from consumers, families and providers, 1 deputy director to supervise the staff, two policy staff and one volunteer coordinator. The cost will also include space rental for the regional staff, travel and other supplies. Total cost of this portion of the proposal before federal financial participation is $1.283 million in fiscal years (FY) 2018-19 and $2.918 million in FY 2020-21.

MAARC Operational and Contingency Staffing and Support; federally licensed facilities:

The proposal increases funding for the current MAARC call center contract and MAARC MN.IT costs.

The increase in the call center contract before financial participation is $1.4 million in FY 2018-19 and $3.079 million in FY 2020-21.

The total MN.IT costs before federal participation is $1.160 million in FY 2018-19 and $1.318 million in FY 2020-21.

MN.IT costs include:

- Funding for 24/7 off-hour support for call center questions/issues, applications and server issues.
- Funding for creating a single point of entry for all elder abuse reporting, import current Nursing Home Incident Reporting (NHIR) fields and form data into the MAARC form and create monitoring and reporting of timeliness of reports to Department of Health and CMS.

The overall total cost of this portion of the proposal before federal financial participation is $2.560 million in FY 2018-19 and $4.397 million in FY 2020-21.

Law Enforcement Notification Enhancement:

These costs include an FTE for a two year project manager to complete the integration of the law enforcement notification enhancements requested. The total cost for the FTE before federal financial participation is $114,000 in FY 2018-19 and $103,000 in FY 20-21.

In addition, several MN.IT costs are included in the estimate. The total time for completion is estimated to be two years. The total cost for the MN.IT costs is $684,000 in FY 2018-19 and $958,000 in FY 2020-21:

- An electronic submission process for police reporting that will not only be more efficient for law enforcement (LE) agencies, but will reduce the manual entry of information. To meet this requirement, it has been requested to utilize a system other than PDF. The Bureau of Criminal Apprehension has developed and maintains a system that is utilized by all LE agencies for ease of communication.
- Incorporate GIS technology to assist the MAARC call center in identifying the correct LE agency.
- Create and maintain a list of the law enforcement business organizations for Emergency Protective Services notifications to provide a timely and efficient means of communicating the need for emergency protective services.
- Ongoing operational funding.

Total cost of this portion of the proposal before federal financial participation is $798,000 in FY 2018-19 and $1.061 million in FY 2020-21.

Assisted Living Stakeholder process:
One FTE is needed to collaborate with Minnesota Department of Health staff andwork closely with the Ombudsman for Long-Term Care to facilitate the stakeholder process and engagement. Total cost of this portion of the proposal before federal financial participation is $120,000 in FY 2018-19 and $264,000 in FY 2020-21.

Grants for adult protection:
The proposal would allocate grant funding to counties and tribes based upon a formula under a new subsection in Minnesota Statute 256M. The formula allocates 25 percent of the funding based on the number of reports of suspected vulnerable adult maltreatment under Minnesota statute sections 626.557 and 626.5572 and allocates 75 percent of the funding based on the number of screened-in reports for adult protective services or vulnerable adult maltreatment investigations. Funding to counties and tribes would be based upon the previous year's data held by the Commissioner of DHS. The funding total for allocations increases by $500,000 each year through FY 2021.

Total cost of this portion of the proposal is $3.0 million in FY 2018-19 and $7.5 million in FY 2020-21.

DHS Appeals Division:

The proposal will require 6 FTE to manage the anticipated additional case load noted in the budget proposal. The FTEs are as follow: (5) human services judges and (1) support staff. Total cost of this portion of the proposal before federal financial participation is $679,000 in FY 2018-19 and $1,420,000 in FY 2020-21.

DHS Licensing:

The proposal will require 5 FTE in DHS's Licensing Division. The FTEs are as follow: (2) FTEs to increase protection to vulnerable adults who are subject of a MAARC report for which DHS is the agency responsible for investigation and protection, (1) FTE to ensure that the intake and investigations unit has the resource to be able to appear in human services hearings and to continue to efficiently process investigations, and (2) FTE to prepare reports for dissemination to the vulnerable adult and interested parties and process the various notification to interested parties and law enforcement. Total cost of this portion of the proposal before federal financial participation is $519,000 in FY 2018-19 and $1.070 million in FY 2020-21.

IT Related Proposals:

This proposal will require MNIT staffing costs as noted above in the fiscal section above. The MAARC is integrated within the SSIS system, so resources for these changes will be directed to the SSIS system.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			289	6,583	6,872	7,361	7,312	14,673
HCAF								
Federal TANF								
Other Fund								
Total All Funds			289	6,583	6,872	7,361	7,312	14,673
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	14	CCA admin- Ombudsman	0	1,283	1,283	1,459	1,459	2,918
GF	14	CCA admin- Law Enforcement Notification enhancement	0	114	114	103	0	103
GF	11	MNIT costs- Law Enforcement Notification enhancement- SSIS	0	411	411	493	82	575
GF	46	Children and Community Services grants	0	3,000	3,000	3,500	4,000	7,500
GF	14	CCA Assisted Living stakeholder engagement	0	120	120	132	132	264
GF	14	CCA Admin- MAARC operational\federal requirements contract	0	1,400	1,400	1,492	1,587	3,079
GF	11	MNIT costs- 24/7 - SSIS	0	209	209	209	209	418
GF	11	MNIT costs- DHS single entry- SSIS- MDH	114	114	228	45	45	91
GF	11	MNIT costs- DHS single entry- other	175	175	350	232	100	332
GF	14	35% FFP – CCA admin	0	(1,021)	(1,021)	(1,115)	(1,112)	(2,227)
GF	11	Operations Licensing	0	519	519	535	535	1,070
GF	11	Operations Appeals	0	678	678	711	710	1,421
GF	REV1	35% FFP - Operations	0	(419)	(419)	(436)	(436)	(872)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	14	CCA admin FTE's	0	12		12	11	
GF	11	Operations	0	11		11	11	

Agency Name

FY18-19 Biennial Budget Change Item

Change Item Title: Expand and Strengthen School-Linked Mental Health (CS-58)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	0	5,223	5,248	5,248
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	5,223	5,248	5,248
FTEs	**0**	**3**	**3**	**3**

Request:

Effective July 1, 2018, the Governor recommends increasing funding for school-linked mental health grants by $5 million per year in order to serve approximately 7,500 more students, strengthen the quality of school-linked mental health services and build capacity to bring services statewide. The proposal also provides administrative resources to provide on-going support and technical assistance to grantees as well as measure the impact of the program.

Proposal:

This proposal seeks to increase access to mental health services for K-12 students in Minnesota by expanding school-linked mental health grants in order to build capacity and improve the effectiveness of these services. Under Minnesota's model of school-linked mental health, community mental health agencies place mental health professionals and practitioners in partnering schools to provide mental health services to students. These mental health providers also consult with teachers and provide care coordination as well as offer classroom presentations and school-wide trainings on mental health issues.

The current base level funding for school-linked mental health grants is $11 million per year. This proposal will increase annual funding for school-linked mental health grants by $5 million beginning July 1, 2018 to reach more students and more regions of the state. This increase in grant funding will also be used to train grantee organizations to implement evidenced-based practices, including best practices for working with children who have experienced trauma as well as specialized training for providers who serve younger children and their parents. Training on evidenced-based practices will continue into the next grant cycle as well as focusing on building the capacity and workforce in areas that have the most barriers to bringing school-linked mental health to their district, school building and students.

Since 2007, Minnesota has pioneered efforts to bring mental health services to students through the school-linked mental health program. The current grantees provided 14,971 students with school-linked mental health services. Grantees are in 287 school districts (52% of total school districts) within 953 schools buildings (46% of total public school buildings). In the most recent round of funding, DHS has moved towards a regional approach that allows for greater collaboration among providers/schools, less disruption for clinical care when providers move in/out of schools, ensures coverage in most areas of the region, and incentivizes providers to work together to design the service delivery in their region.

With the additional funding, school-linked mental health grantees will be able to serve approximately 7,500 more students over the next two years. This proposal will allow grantees to serve more students in districts already covered by the program by increasing the number of hours providers are available at a specific school and train providers to utilize evidenced-based practices, which is expected to improve outcomes for students accessing these services.

Finally, the proposal requests administrative funding to support the expansion of the program and allow for a greater focus on measuring and improving quality through data analysis, proactive support for grantee provider agencies and work collaboratively with other systems and agencies to find efficiencies. The resources will allow for the department to provide consultation for complex administrative functions, clinical treatment services, and program requirements for publicly financed children's mental health programs, as well as evaluate client access to care, efficiency and fairness of delivery, appropriateness of care, and the quality and effectiveness of that care.

Rationale/Background:

Mental health problems are common, affecting one in every five young people. In Minnesota, nine percent of school-age children and five percent of preschool children have a serious emotional disturbance, which is a mental health problem that has become longer lasting and interferes significantly with the child's functioning at home and in school. An estimated 109,000 children and youth, birth to age 21, in Minnesota need treatment for serious emotional disturbances.

With appropriate identification, evaluation, and treatment, children and adolescents living with mental illnesses can achieve success in family life, school, and work. However, the overwhelming majority of children with mental health issues fail to be identified and lack access to treatment and supports. School Linked Mental Health services have proven particularly effective in reaching children who have never accessed mental health services. Many children with serious mental health needs are first identified through this program, including 45 percent of children who met the criteria for Severe Emotional Disturbances (3,749 children total). In addition, students of color served were significantly more likely to be accessing mental health services for the first time compared to white students (58 percent to 52 percent).

Untreated mental health issues are also a significant barrier to learning and educational success. Placing children's mental health services in schools provides a great opportunity for the early identification, intervention and even prevention of serious mental health issues among students.

School-linked mental health services are not yet available statewide and there is capacity among current grantees to expand to additional regions and provide more hours of coverage if additional resources were available. While the program has been a major success, grantee organizations need support to train their staff on the latest best practices and to implement those practices in their work in order to maximize the effectiveness of the program. Additionally, grantee organizations have requested a level of technical support that DHS currently lacks the administrative capacity to provide.

Fiscal Impact:

This proposal increases funding for school-linked mental health grants by $5 million in FY 2019 on-going. This proposal also includes funding for 3.0 FTEs on-going in the Mental Health Division of the Community Supports Administration at the Department of Human Services beginning in FY 2019. Additional administrative resources are included as follows: $30K annually to allow staff to travel throughout the state to provide technical assistance and monitor programs; $15K annually for a technical contract with Wilder Research for access to their MN Kids Database to allow providers and staff to document and analyze utilization information; and $10K annually for a statewide conference to provide training and sharing of best practices. Both the grants and the administrative resources utilize general fund appropriations.

1.0 FTE is required to lead the development, design and implementation of monitoring practices for the School-Linked Mental Health Infrastructure Development grants and the Mental Health Innovation Grants for Intermediate School Districts. This position will monitor and evaluate operations, formulate policy, plan, and provide technical assistance and quality assurance and compliance monitoring for these grant programs. In addition, this position will work with internal and external stakeholders to design an effective, clinically and culturally competent, and child and family responsive children's mental health system of care.

This position will work with grantees and sub-contractors, schools, county mental health, public health, and social services agencies, children with mental health disorders and their families, children's mental health collaborative and family services collaborative, Tribal Councils and Governments' health services agencies and clinics, Community Mental Health Centers; Minnesota Departments of Health, Education, Corrections, and Employment and Economic Development, Managed Care Organizations, advocacy organizations interested in children's mental health issues, and the State Mental Health Advisory Council and Children's Subcommittee.

In addition, 2.0 FTE will conduct comprehensive longitudinal analyses incorporating service utilization and clinical outcomes from a variety of sources on multiple platforms. They are responsible for establishing technical methods to verify the content as complete, accurate, and timely.

Databases, reporting applications, and analyses will be used to evaluate the performance of statewide mental health care providers and to identify gaps in the service delivery system and to conceptualize solutions. In addition, these staff will analyze data collection and reporting methodologies throughout the mental health care delivery system and school systems with Positive Behavioral Interventions and Supports (PBIS) framework, and propose changes at all levels to reduce reporting inefficiencies/redundancies and improve accountability throughout the care delivery system.

Equity and Inclusion:

The purpose of the proposal is to expand access to and improve the quality of children's mental health services by providing school-based and school-linked mental health services via partnerships between public schools and programs and MHCP-enrolled mental health provider agencies, or Tribal Mental Health Authorities.

The school-linked mental health program has been adjusted in recent years to support an expansion of culturally and linguistically diverse services and providers. This includes the first tribal school-linked program, an agency contracting with state academies for deaf/hearing impaired and blind/visually impaired students and allowing "practice groups" of providers to become eligible grantees in order to encourage small, culturally-specific providers access to the program to support students in their communities.

These grant dollars are intended to continue to develop and to sustain the statewide infrastructure necessary to ensure that children with mental health conditions, regardless of their insurance status, receive evidence-based mental health services from highly-trained mental health professionals.

IT Related Proposals: None.

Results:

Success of this proposal will be measured as follows:

- Increase in the number of school districts and schools accessing mental health services through the grant
- Increase in the number of school districts and schools utilizing telemedicine delivery of mental health services
- Increase in the number of school districts who have both a School-Linked Mental Health (SLMH) and Positive Behavioral Interventions and Supports (PBIS) framework
- Increase in the number of clinicians available to provide mental health treatment in a school setting
- Increase in the number of students of cultural minority groups receiving mental health services through the grant
- Increase in the number of mental health clinicians who are trained in and providing Evidence-Based Practices (EBP)
- Improve mental health symptoms in youth who receive an Evidence-Based Practice (EBP) treatment
- Improve early identification and interventions of mental health issues in elementary and middle school settings
- Increase in technical assistance resources to grantees and schools and external stakeholders to promote regional efforts in school mental health best practices

Statutory Change(s): None.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund				5,223	5,223	5,248	5,248	10,495
HCAF								
Federal TANF								
Other Fund								
Total All Funds								
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	15	MH Admin		343	343	381	381	762
GF	58	Children's Mental Health Grants		5,000	5,000	5,000	5,000	10,000
GF	Rev1	FFP @ 35%		(120)	(120)	(133)	(133)	(266)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	15	MH Admin – assumes 9 months in SFY19		3		3	3	

Department of Human Services

FY18-19 Biennial Budget Change Item

Change Item Title: Clarification of Inflation Adjustments in the Disability Waiver Rate System (CS-57)

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

Request:

Effective July 1, 2018, the Governor recommends clarifying state statute governing inflation adjustments in DWRS to align state law with federal requirements. This proposal will clarify the interaction between previously legislated after-model rate adjustments and automatic inflationary adjustments within DWRS so that rate formulas contain one mechanism to incorporate inflationary changes and the rate methodology appropriately reflects provider costs.

This proposal will not impact Medical Assistance spending. The MA spending forecast currently reflects the requirement from Minnesota's updated federal waiver plans to remove after-model rate adjustments upon implementation of the automatic inflationary adjustments within DWRS.

Proposal:

This proposal modifies existing statute governing rate setting for Minnesota's disability waivers. This proposal clarifies the interaction between after-model rate adjustments authorized by the Legislature in 2013 and 2014 and the automatic inflationary adjustments in current DWRS statute. Additionally, this proposal clarifies the interaction between any future legislated after-model rate adjustment and the automatic inflationary adjustments. This proposal results in service rates that appropriately reflect average provider costs over time by requiring that rate formulas are appropriately modified to account for inflation.

DWRS service rates are based on average provider costs across the state. The rate formulas are made up of cost components such as direct care staff wages, employee benefits, taxes, and administrative costs. In order for rates to appropriately reflect changes in the cost of providing services over time, current law requires that DWRS cost components be adjusted once every five years for inflation. These automatic adjustments replace cost component values with updated data from the Bureau of Labor Statistics (BLS) and the Consumer Price Index (CPI). The first automatic increase was implemented on July 1st, 2017 and resulted in an average percent rate increase of 8.5%.

In the initial years of DWRS implementation prior to the first automatic inflationary adjustment, the Legislature also authorized three separate after-model rate adjustments to account for increased costs over the same time period. This percentage, totaling 7%, was applied as an after-model percentage to DWRS rate frameworks.

The inclusion of both adjustments in the cost-based rate formulas results in duplicate inflationary adjustments over the same time period and results in the application of after-model factors to the rate methodology that are not attributed to the cost required to provide services. The federal Centers for Medicare and Medicaid Services (CMS) requires Minnesota to provide a basis and rationale for all rate components within the methodology. CMS also requires the state to appropriately rebase rates according to inflationary changes over time. Duplicate inflationary mechanisms do not appropriately rebase rates over time.

In February 2018, CMS notified the state that rate formulas cannot include duplicate inflationary factors over the same time period. As required by CMS, updated federal waiver plans clarify that previous after-model cost of living adjustments are required to be removed from DWRS rate calculations upon implementation of the automatic inflationary adjustments.

This proposal will reflect the required clarifications in the federal waiver plans. This proposal will amend state law to reflect the clarification that after-model rate adjustments will be removed upon implementation of the automatic inflationary adjustments. This proposal will clarify that rate calculations with the automatic inflation adjustments will not also include the after-model rate adjustments. This clarification only removes the after-model rate adjustments from the DWRS rate calculations and does not remove these adjustments from historic rates used for banding. When banding ends, service rates that are currently banded will reflect inflationary increases provided from the automatic inflation adjustments. Additionally, shortly after the removal of banding, service rates will receive the next automatic inflationary adjustment in 2022.

This proposal will also clarify the interaction between future out-of-model rate adjustments and the five-year automatic inflationary adjustments to ensure that duplicate inflationary adjustments do not occur in the future.

This proposal will clarify that there is only one inflation mechanism applied to the DWRS rate structure. This proposal will ensure that:

1. HCBS service rates appropriately reflect provider costs; and
2. Minnesota maintains compliance with the federal Centers for Medicare and Medicaid Services

Rationale/Background:

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

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

In order to maintain ongoing compliance in federal waiver plans going forward, cost components used to calculate rates will be required to be outlined and justified. CMS requires rate frameworks to be rebased at least once every five years. This proposal will help ensure ongoing federal compliance with CMS by appropriately setting cost components over time, having a data-based source for framework component values, and maintaining continued access to disability waiver services.

Fiscal Impact:

This proposal will not impact Medical Assistance spending, as Minnesota's updated federal waiver plans require the removal of legislated after-model rate adjustments upon implementation of the automatic inflationary adjustments within DWRS.

Equity and Inclusion:

This proposal has no equity-related impacts.

IT Related Proposals:

This proposal has no IT-related costs.

Results:

This proposal will align state law with Minnesota's federal waiver plans and federal rate-setting requirements. This proposal will help ensure that the rate frameworks appropriately reflect the average costs incurred by service providers over time.

Statutory Change(s):

MS § 256B.4914

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund								
HCAF								
Federal TANF								
Other Fund								
Total All Funds								
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
Fund	**BACT#**	**# OF FTE's**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Agency Name

FY18-19 Biennial Budget Change Item

Change Item Title: CCAP Program Improvements (CF-43)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	0	2,523	7,191	7,702
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	2,523	7,191	7,702
FTEs	**0**	**2**	**2**	**2**

Request:

Effective beginning in fiscal year 2019, the Governor recommends investments of $2.52 million in 2018-2019 and $14.89 million in 2020-2021 to improve the Child Care Assistance Program (CCAP). These investments support family stability and improve the safety and school readiness of children served in child care settings across the state. These investments also comply with federal requirements.

Rationale/Background:

The Child Care Assistance Program (CCAP) helps families pay for child care so that parents can work or go to school. It also helps ensure that children are well cared for and prepared to enter school ready to learn. CCAP serves approximately 15,000 families and 30,000 children each month. Over 60 percent of the children served are ages 5 or younger. Over 65 percent of all children served are children of color or American Indian children. Approximately 3,450 providers are paid each month for serving children receiving CCAP. CCAP is administered by county and tribal agencies.

This proposal will impact many children and families served by CCAP and improve their experiences with the program. The changes make it easier for families to continue receiving assistance, make child care available to more families who are homeless, ensure providers have due process rights, and help ensure that children are safe.

These changes are required under the federal Child Care Development Block Grant (CCDBG). In Federal Fiscal Year 2017, Minnesota received $91.48 million from the CCDBG. These funds help pay for initiatives to improve the quality of child care and for the Child Care Assistance Program, which includes Basic Sliding Fee child care and Minnesota Family Investment Program child care.

Most changes to CCAP were federally required to be implemented by Sept. 30, 2016. Minnesota did not comply with this timeline. The federal Office of Child Care has approved a waiver extension for Minnesota, until Sept. 30, 2018. If Minnesota is not in compliance by this date, it is possible that Minnesota will face penalties, including a reduction of CCDBG funds.

Proposal:

Improvements to the Child Care Assistance Program

These changes will improve the experiences that children and families have with the Child Care Assistance Program (CCAP).

Ensures that families do not lose assistance during their 12 month eligibility period by:

- Eliminating the six month limit on Portability Pool for families who move between counties. It is federally required to continue assistance until the family's next redetermination; this proposal meets federal requirements and ensures families do not lose eligibility due to current Portability Pool time limits. The cost of this provision is $72 thousand in FY 2018-19 and $287 thousand in 2020-21.
- Ensuring that families who received Minnesota Family Investment Program/Diversionary Work Program (MFIP/DWP) for at least one of the last six months will qualify for Transition Year child care. It is federally required to continue assistance until the family's next redetermination; this proposal meets federal requirements by ensuring all families who had received MFIP child care will meet the Transition Year child care requirements. To maintain program simplicity, this proposal also allows families

who had not received MFIP child care to qualify for Transition Year child care with one month of MFIP receipt. The cost of this provision is $1.48 million in FY 2018-19 and $9.12 million in 2020-21.

- Allowing families to receive assistance until their next redetermination when a child turns 13 years old or a child with a disability turns 15 years old. It is federally required to continue assistance until the family's next redetermination; this proposal meets this federal requirement. The cost of this provision is $0.65 million in FY 2018-19 and $4.12 million in 2020-21.

Makes child care available to more homeless children by:

- Creating an expedited five business-day application process for families who are homeless. Proof of eligibility would be required within three months (but not prior to approval) or assistance would end. It is federally required that states expedite applications for homeless families, including processing applications faster and prior to receiving proof of eligibility. This proposal meets federal requirements. The federal rule generally requires that assistance be provided for at least three months; therefore proof of eligibility could likely not be required sooner than three months. States have discretion to determine the processing timeframe; the five day limit aligns with expedited SNAP issuance. The cost of this provision is $56 thousand in FY 2018-19 and $984 thousand in 2020-21.

Expands due process rights for providers by:

- Transferring appeal rights from families to providers, who have the knowledge to argue on their own behalf, when adverse actions are taken against them. For all adverse actions, providers will have the right to either a fair hearing, an administrative review, or a hearing that is consolidated with licensing. This provision includes 2 staff positions to handle the appeals. This achieves a federal requirement to create a formal process for providers to address actions taken against them. The method proposed by DHS builds on existing infrastructure, rather than creating a new process. This proposal meets federal requirements. The cost of this provision is $223 thousand in FY 2018-19 and $375 thousand in 2020-21.

Ensures that children are cared for in safe, nurturing environments by:

- Requiring that non-relative legal non-licensed providers who care for children receiving CCAP meet basic health and safety standards, including annual monitoring visits, and training on health and safety topics. It is federally required to conduct annual monitoring visits for non-relative providers; this monitoring visit proposal meets federal requirements. It is federally required that legal-nonlicensed providers meet basic health and safety standards; states have some discretion in determining the specific standards; this training proposal has been partially implemented and meets federal requirements. This provision has no cost.
- Requiring that out-of-state providers meet federal health and safety requirements to receive Minnesota CCAP payments. It is federally required for providers to meet health and safety standards; this proposal meets federal requirements. This provision has no cost.
- Eliminating the option to pay legal non-licensed providers before a background study has been completed. No counties currently use this option. It is federally required for providers to have background studies; this proposal meets federal requirements. This provision has no cost.

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Fiscal Impact:

Current base funding for MFIP Child Care Assistance and BSF Child Care Assistance for 2018-19 is $290.38 million general fund, $258.77 million federal funds and $5.88 million in county funds. This base funding provides subsidies for child care to families with low-incomes.

Expanding due process rights for providers includes DHS staff and systems costs. All other proposal costs are for direct services and systems.

Equity and Inclusion:

Over 65 percent of the children served by CCAP are children of color or American Indian children.

Race and Ethnicity, by percent, of children in the Child Care Assistance Program

State Fiscal Year	African American	American Indian	Asian or Pacific Islander	Hispanic or Latino	Multiple Races	White	Unknown
2017	51.4	1.2	1.8	5.2	6.4	29.8	4.2

State Fiscal Year	African American	American Indian	Asian or Pacific Islander	Hispanic or Latino	Multiple Races	White	Unknown
2016	48.4	1.3	2	5.5	6.8	31.9	4.1
2015	46	1.4	2.1	5.7	7.0	33.8	4
2014	41.5	1.6	2.5	6.2	7.4	37.5	3.3
2013	38.4	1.9	2.6	6.7	8	39.7	2.7

Monthly average percentage of children in CCAP Caseload of all ages by state fiscal year. Small changes from previous state fiscal year reports are due to minor changes in data methodology.

IT Related Proposals:

The Minnesota Electronic Child Care Systems, or MEC^2, the automated case management computer system that supports the Child Care Assistance Program will need to make changes to implement most of the proposals. Costs for this are $177 thousand in 2018-19 and $70 thousand in 2020-21.

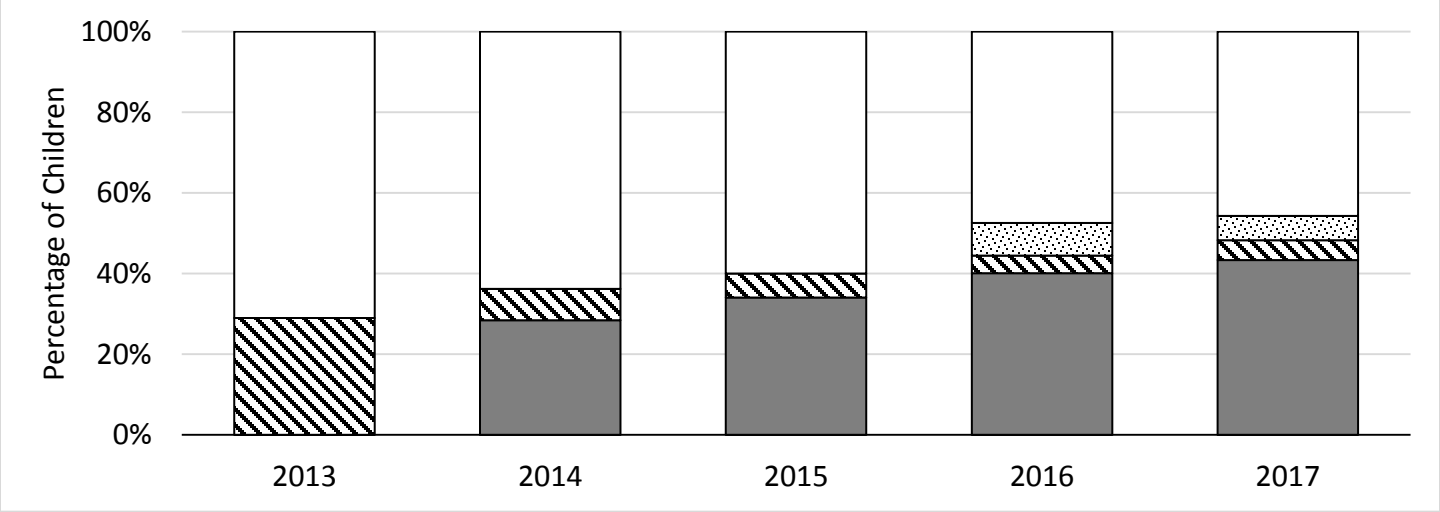
Results:

Children who participate in high quality early care and education are more likely to have school success and positive life-long outcomes. The percent of children ages zero to five receiving CCAP who use providers eligible for the higher rates for quality has increased from 29 percent in 2013 to 48 percent 2017.

In 2014 providers with a Parent Aware rating of Three- or Four-Stars began receiving the CCAP higher rates for quality. Previously only providers with certain accreditations and family child care providers with certain credentials were eligible for the higher rates for quality.

The policies in this proposal work to keep children in child care with fewer disruptions and more consistent schedules. This will allow more families to choose high quality care and encourage high quality providers to serve more children receiving child care assistance. This will help increase the percent of children receiving child care assistance in high quality settings.

Growth of High Quality Care Use among Children Receiving CCAP Ages 0 to 5



	Child's Provider Credentials	2013	2014	2015	2016	2017
	Provider holds Parent Aware 3-4 Star*	NA	28%	34%	40%	43%
	Provider holds Accreditation*	29%	8%	6%	5%	5%
	Provider holds Parent Aware 1-2 Star	NA	NA	NA	8%	6%
	Standard Care	71%	64%	60%	47%	46%

* These providers are eligible for CCAP higher rates for quality.

Data notes:

- Percentages based on unduplicated child count using July service month of each year.

- Any child using multiple providers during the service month is counted based on their providers' highest credential ranking. The ranking, from highest to lowest, is Parent Aware 3-4 Star, Accreditation, Parent Aware 1-2 Star, and Standard Care.
- NA indicates the CCAP data system (MEC^2) did not track provider Parent Aware ratings of this type at this time.

Statutory Change(s):

Minnesota Statutes, Chapter 119B will require changes.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			0	2,523	2523	7191	7702	14,892
HCAF								
Federal TANF								
Other Fund								
Total All Funds								
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	22	MFIP/TY	0	1,902	1,902	6,085	6,556	12,641
GF	42	BSF	0	304	304	900	940	1,840
GF	11	Operations(MEC2)	0	177	177	35	35	70
GF	11	Operations (FTE 0,2,2,2) Due Process Appeals		216	216	249	249	498
GF	REV1	FFP @ 35%		(76)	(76)	(78)	(78)	(156)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	11	Operations Due Process Appeals	0	2		2	2	

Agency Name

FY18-19 Biennial Budget Change Item

Change Item Title: Adjustment to the Child Support Threshold and Federal Fee Increase Financing (CF-47)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	0	382	382	382
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	382	382	382
FTEs	**0**	**0**	**0**	**0**

Request:

Effective beginning in fiscal year 2019, the Governor recommends investments of $382 thousand in 2018-2019 and $764 thousand in 2020-21 for a required modification to the child support case management system, PRISM, and to pay for the federal share of the increased annual child support fee to prevent a loss of funding to local agencies due to changes in the Federal law.

Proposal:

This proposal makes changes to Minnesota Statute § 518A.51 and to PRISM that are necessary to conform to recent changes in federal law governing the Federal Annual Fee for child support services and to avoid adverse impacts on local child support agencies. The proposal would increase Minnesota's threshold for collecting the annual fee for child support services from $500 to $550, and absorb the state share of the federally required $10 fee increase paid by custodial parents who have never received public assistance rather than passing that fee increase through to parents. These new federal requirements are effective on October 1, 2018. This proposal will also prevent a reduction in the non-federal share of the annual fee collection that is retained by local agencies.

Rationale/Background:

Federal law requires that states collect an annual fee for child support cases maintained by the child support agency. Federal regulations allow the state to pay this fee or pass it on to the custodial parent. The fee applies when the child(ren) on the case have never received public assistance. Currently, the fee is $25, and is assessed on cases after $500 is collected in a year.

On February 9, 2018, President Trump signed the Bipartisan Budget Act of 2018. The new law includes a provision that changes the federal annual fee states must collect on non-public assistance child support cases from $25 to $35. Currently, the fee is paid only after $500 is collected in the federal fiscal year. Federal law changes require that the threshold to be raised to $550. These changes are effective October 1, 2018.

The federal government collects the fee from states by requiring the state to report the fee as program income and reducing reimbursement to states by the federal share (66%) of the reported program income. In FY 2017 the state collected $1,435,494 in annual child support fees, representing approximately 57,420 cases. Therefore, it is estimated that an additional $574,200 will be reported as program income to the federal government annually. Federal payments to the state will be reduced by 66% of that amount, or $382,000.

By not passing the $10 fee increase to the custodial parent, a budget hole is created which would effectively reduce the non-federal share of the child support annual fee. The non-federal share is distributed to local child support agencies as incentive payments. The proposal replaces this lost revenue which will hold the local agencies harmless.

After October 1, 2018, there is no authority for Minnesota to collect on cases above the current $500 threshold and below the new $550 threshold. To avoid violation of federal law, it is important that this statute be changed to the higher threshold.

Fiscal Impact:

This proposal appropriates funds to prevent the loss of $382,000 which will occur beginning October 1, 2018 due to federal law changes to the child support annual fee.

IT Related Proposals:

The child support case management system, PRISM, will require changes to forms and programming. The total cost is $44,023 with a state share of $15,000 in 2018-2019 and no cost in 2020-2021.

Statutory Change(s):

Minnesota Statutes 518A.51

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			0	382	382	382	382	764
HCAF								
Federal TANF								
Other Fund								
Total All Funds			0	382	382	382	382	764
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	11	System State Share (PRISM@34%)	0	15	15	0	0	0
GF	44	Child Support Enforcement Grants	0	367	367	382	382	764
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Department of Human Services

FY18-19 Supplemental Budget Change Item

Change Item Title: Refinancing Consolidated Chemical Dependency Treatment Fund Operations (CS-46)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	0	2,033	(2,796)	(2,849)
Revenues	0	(10,823)	(1,491)	(1,491)
Other Funds				
Expenditures	0	4,911	9,740	9,793
Revenues	0	(4,911)	(9,740)	(9,793)
Net Fiscal Impact = (Expenditures – Revenues)	0	(8,790)	(4,287)	(4,340)
FTEs	**0**	**0**	**0**	**0**

Request:

Effective July 1, 2018, the Governor recommends refinancing operations related to the Consolidated Chemical Dependency Treatment Fund (CCDTF) from the General Fund.

Proposal:

This proposal changes how the administration of CCDTF is financed in order to provide greater transparency in CCDTF financing, eliminate recurring excess balances in the special revenue account and generate savings to the general fund. The proposal allows federal Medical Assistance revenues generated by the CCDTF to fully offset the cost of CCDTF services and transitions funding for the administration of substance use disorder services from the CCDTF administrative special revenue account into the state's general fund. The CCDTF administrative special revenue account will be eliminated with the accumulated balance transferring to the GF following July 1, 2018. The refinancing generates a savings to the general fund in the process.

Rationale/Background:

Historically, a variety of administrative functions (licensing, data collection, claim processing, policy, and technical assistance support) related to the operation of the CCDTF have been funded by dedicating a percentage of Medical Assistance revenues to a special revenue account for this purpose. This funding structure has led to fluctuations within the CCDTF administrative account that have been challenging to manage and difficult for those outside the organization to understand. The present proposal places the funding of these administrative functions on general fund appropriations and allows the full value of federal funding earned on substance abuse treatment funded by the CCDTF to accrue to the CCDTF.

The CCDTF combines several funding sources – Medical Assistance (MA), state appropriations, county funds and Federal Substance Abuse Block grant funding - into a single fund with a common set of eligibility criteria. The CCDTF pays for Substance Use Disorder (SUD) treatment services for people on fee-for-service MA and people who do not have insurance coverage but who meet the income guidelines for MA. Services for people on an MA managed care plan or MinnesotaCare, are not paid for through the CCDTF, but through those respective health care programs. The CCDTF also pays the room and board portion of costs for residential treatment, including for individuals on an MA managed care plan or MinnesotaCare. Since 1988, counties have had a financial share of the treatment paid for through Minnesota's Consolidated Chemical Dependency Treatment Fund (CCDTF).

Fiscal Impact:

In the FY18-19 biennium, this proposal shifts $4.9 million in Medicaid revenue from the CCDTF administration account into the CCDTF, freeing up a like amount of general fund appropriations in the CCDTF. In turn, the CCDTF administrative costs (29.1 FTEs, indirect costs and $2.4 million annual state share of systems costs) are funded through general fund appropriations. Because the projected dedicated and non-dedicated revenues exceed the general fund costs, the proposal results in a savings to the general fund.

Statutory Change(s):

MS § 254B.02, Subd 1; 254B.06, Subd. 1 & 2

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund				(8,790)	(8,790)	(4,287)	(4,340)	(8,627)
HCAF					0			0
Federal TANF					0			0
Other Fund				0	0	0	0	0
Total All Funds			$0	(8,790)	(8,790)	(4,287)	(4,340)	(8,627)
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
DED	Rev	MA admin FFP to CCDTF Program		(4,911)	(4,911)	(9,740)	(9,793)	(19,533)
DED	35	Dedicate all MA admin to CCDTF Program		4,911	4,911	9,740	9,793	19,533
GF	35	Swap Out like amount of GF from CCDTF		(4,911)	(4,911)	(9,740)	(9,793)	(19,533)
GF	35	Trans In admin balance from previous year		(9,332)	(9,332)	0	0	0
GF	11	GF Licensing Costs		800	800	800	800	1,600
GF	15	GF ADAD Costs		3,460	3,460	3,460	3,460	6,920
GF	Rev1	Admin FFP @ 35%		(1,491)	(1,491)	(1,491)	(1,491)	(2,982)
GF	11	GF for CCDTF systems cost		2,434	2,434	2,434	2,434	4,868
GF	11	Replace lost indirect costs		250	250	250	250	500
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Human Services

FY18-19 Biennial Budget Change Item

Change Item Title: Rate Increase for Personal Care Assistance and Self-Directed Programs (CS-59)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	0	12,000	12,180	11,820
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	12,000	12,180	11,820
FTEs	**0**	**0**	**0**	**0**

Request: The Governor recommends investing $12 million in FY 2018-19 and $24 million in FY 2020-21 to increase rates within personal care assistance services and other self-directed services, and make short term investments to improve access to these services.

Proposal: This proposal provides a 1.69 percent increase for personal care assistance services and self-directed direct support services effective July 1, 2018. In addition, the proposal also provides funding for the Department of Human Services to make targeted time-limited investments in activities to enhance self-directed services across the state.

Rationale/Background: People with disabilities and older adults who rely on direct support services to live, work, and participate in their communities are facing a severe shortage of workers to provide these essential services. The difficulty finding and retaining direct support workers puts people who rely on those services at risk of neglect and hospitalization. The workforce shortage jeopardizes their ability to remain in the most integrated settings possible in accordance with Minnesota's Olmstead Plan.

Two primary strategies to mitigate the direct support workforce shortage are attracting additional workers to the profession and improving the retention rate of existing workers. Investing in the rate for these services will improve access to these services by enabling provider agencies and people who use services to increase wages and improve benefits for direct support workers. Rate increases would support provider agencies and people who use services to implement strategies to recruit and retain workers.

The short-term investments in fiscal years 2019-2020 could address the workforce shortage through a number of different interventions such as: increasing the awareness of these services as employment opportunities for potential workers, improving recruiting and retention strategies among provider agencies and people who use services, and promote training opportunities. Investments in training targeted at people who use services and provider agencies would improve job satisfaction for workers by improving the supervision and support workers receive, building a common understanding of the differences in service models, clarifying the scope of direct support services billable to Medical Assistance through self-directed services, and supporting the dissemination of best practices among provider agencies.

Fiscal Impact: The rate increase will have a cost of $10.080 million in FY 2019 and $23.781 in FY 2020-21. Total available for training and other quality investments will be $1.92 million in FY 2019 and $219,000 in FY 2020-21.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			0	12,000	12,000	12,180	11,820	24,000
HCAF								
Federal TANF								
Other Fund								
Total All Funds			0	12,000	12,000	12,180	11,820	24,000
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	33	MA-PCA Rates	0	10,080	10,080	11,961	11,820	23,781
GF	15	CSA Admin	0	1,920	1,920	219	0	219
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Human Services

FY18-19 Supplemental Budget Change Item

Change Item Title: Repeal Provider Tax Sunset (HC-56)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	12,174	29,270
Revenues	0	0	(250,866)	(747,913)
Net Fiscal Impact = (Expenditures – Revenues)	0	0	(238,692)	(718,643)
FTEs	**0**	**0**	**0**	**0**

Recommendation:
The Governor recommends repealing the sunset on the two percent tax on revenue of hospitals, ambulatory surgical centers, health care providers and wholesale drug distributors. The Governor also proposes to restore the rate increases to providers and health plans to offset the cost of paying provider tax on Medical Assistance (MA) and MinnesotaCare revenues. This proposal has a net impact to the Health Care Access Fund by $957 million in the FY2020-21 biennium.

Proposal:
This proposal repeals the sunset of the two percent provider taxes contained in Minnesota Statutes Chapter 295.52. The proposal also increases payment rates to providers and managed care organizations to offset the cost of paying the provider tax on MA and MinnesotaCare expenditures. A transfer from the Health Care Access Fund to the General Fund covers the cost of the rate increase so there is no direct General Fund impact from this proposal.

Rationale/Background:
Minnesota levies a two percent tax on the revenue generated by health care providers and wholesale drug distributers. The revenue from these taxes is deposited into the Health Care Access Fund which supplements funding for health care coverage provided through Medical Assistance (MA) and MinnesotaCare and supports public health activities administered by the Minnesota Department of Health.

The provider tax represents approximately 80 percent of the revenue in the Health Care Access Fund. Under current law, the provider taxes sunset on December 31, 2019. Repealing the sunset of these taxes raises nearly $1 billion in revenue in the FY2020-21 biennium to sustain critical state initiatives that provide access to health care, improve the quality of care, and contain health care costs.

In 2003, the state legislature applied the provider tax to patient revenue from the MA and MinnesotaCare programs and increased provider payment rates by two percent for revenue subject to the tax. In November 2016, the forecast for MA and MinnesotaCare accounted for the provider tax sunset by removing the value of the two percent rate increase effective January 1, 2020. Repealing the provider tax sunset reinstates the two percent rate increase in MA and MinnesotaCare, and transfers funding from the Health Care Access Fund to the General Fund to cover the MA portion.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund				0	0	0	0	0
HCAF				0	0	(238,692)	(718,643)	(957,335)
Federal TANF								
Other Fund				0	0	0	0	0
Total All Funds				**0**	**0**	**(238,692)**	**(718,643)**	**(957,335)**
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
HCAF	REV2	Provider Tax Revenue		0	0	(250,866)	(747,913)	(998,779)
HCAF	TOUT	Transfer to GF		0	0	12,073	29,002	41,075
HCAF	31	MinnesotaCare rate increase		0	0	101	268	369
GF	TIN	Transfer into GF from HCAF		0	0	(12,073)	(29,002)	(41,075)
GF	33	MA rate increase		0	0	12,073	29,002	41,075
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Department of Human Services

FY18-19 Biennial Budget Change Item

Change Item Title: Program Integrity Improvements for Nonemergency Medical Transportation (HC-52)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	0	60	(846)	(920)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	60	(846)	(920)
FTEs	**0**	**2.5**	**2.5**	**2.5**

Request:

The Governor recommends new program integrity measures for the Nonemergency Medical Transportation (NEMT) program in response to federal audit findings released in September 2017. This proposal has a net cost to the General Fund of $60,000 in FY2019 and a savings of $1.8 million in the FY2020-21 biennium.

Proposal:

Through a Request for Proposal, DHS would contract with an entity to perform on-going program integrity audits of NEMT to ensure fee-for-service providers are complying with state and federal standards. The audits would include, but are not limited to, review of driver documentation, confirmation of a medical appointment, and confirmation of distance traveled.

The proposal would also provide resources to DHS to enroll individual NEMT providers. This would ensure each driver is meeting the program requirements as well as allow DHS, when appropriate, to perform enforcement actions on one driver versus an entire company.

This proposal would also clarify that DHS does not need to verify that every single requirement is met within the Special Transportation Certification overseen by the Department of Transportation (DOT). This proposal would clarify that DHS is only responsible to ensure the provider holds a current certification through DOT and does not need to duplicate the work performed as part of the certification process.

Rationale/Background:

NEMT provides MA enrollees with the safest, most appropriate and cost-effective mode of transportation to get to and from medical appointments. In September 2017, the federal Office of Inspector General finalized an audit of Minnesota's NEMT program that showed that over 75% of NEMT rides that were audited did not comply with either state or federal requirements. Of the rides that did not meet the requirements, the ride either lacked sufficient documentation, lacked any documentation, or did not have a corresponding Medicaid service to warrant the trip. These findings were consistent with an evaluation of the NEMT program conducted by the Minnesota Office of Inspector General in 2014. As a result of the 2017 audit, the state was directed to pay $1.9 million dollars, the federal share of improper Medicaid reimbursement, to the Centers for Medicare and Medicaid Services. Total fee-for-service spending on NEMT services is expected to reach $34.2 million in FY2019.

As of July 1, 2016, all NEMT providers are required to be certified by DOT as Special Transportation Service providers. In reviewing the requirement, there have been questions whether DHS is required to confirm a provider has a certification or if DHS is required to verify that the provider has fulfilled each individual requirement to obtain a certificate. This proposal would clarify that DHS is required to verify that a provider has a certificate from DOT, not verify every component of the certification requirements.

Fiscal Impact:

The fiscal impact of this proposal includes the cost of a vendor contract for ongoing audits of the NEMT program for MA fee-for-service and the cost of 2.5 FTE to enroll individual NEMT drivers.

Data from DHS shows that approximately 82% percent of NEMT claims in FY2017 occurred on the same day as a claim for another health care service, and that rides occurring the same day as a health care service accounted for 90% percent of the total spending on fee-for-service NEMT. This estimate assumes that additional oversight and ongoing audit activity will prevent NEMT providers from billing the MA program where the ride does not accompany a health care service resulting in a 10 percent reduction in payments to NEMT providers.

IT Related Proposals:

This proposal would require enrolling NEMT drivers directly with DHS.

Results:

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Percentage of NEMT Claims with Proper Documentation	25%		2014

Statutory Change(s):

256B.0625, subd. 17 and 18

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund				60	60	(846)	(920)	(1,779)
HCAF								
Federal TANF								
Other Fund								
Total All Funds				60	60	(846)	(920)	(1,779)
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	33	MA Grants		(428)	(428)	(1,803)	(1,882)	(3,685)
GF	13	Health Care Admin		686	686	1,377	1,383	2,759
GF	REV1	FFP @ 35%		(240)	(240)	(482)	(483)	965
GF	11	HCA Admin (FTE-Systems Fund)		42	42	62	62	112
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
				1.75		2.5	2.5	