Minnesota Department of Human Services
2014 Governor's Supplemental Budget Recommendations
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Change Item Title: HCBS 4% Rate Increase for Providers, with Quality Component

Fiscal Impact ($000s)	FY 2014	FY 2015	FY 2016	FY 2017
General Fund				
Expenditures	0	64,322	74,698	79,529
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	64,322	74,698	79,529

Recommendation:

Effective July 1, 2014, the Governor recommends a 4% rate increase to providers of Home and Community-Based Services (HCBS). 3% of this rate increase is across the board and will be given to all HCBS providers, 1% is related to quality. This proposal invests $64.3 million in FY2015.

Rationale/Background:

Home and Community-Based Services (HCBS) providers have experienced cuts for the past several years through rate reductions. This proposal would increase financial support to HCBS providers.

Proposal:

Effective July 1, 2014, this proposal gives a 4% rate increase to HCBS providers. 3% of this rate increase is across-the board, and 1% is dedicated to quality.

The following services are included in this proposal:

- HCBS programs: DD Waiver, Elderly Waiver, CADI Waiver, CAC Waiver, Brain Injury (BI) Waiver, Home Health Agencies, Personal Care (fee for service and managed care), Private Duty Nursing, Elderly Waiver (managed care), Alternative Care, Community First Services and Supports, and Essential Community Supports.
- Intermediate Care Facilities for persons with developmental disabilities (ICFs/DD), and Day Training and Habilitation for ICFs/DD residents.
- Disability grant programs: Technology grants, Housing grants, Consumer Support Grant (CSG), Family Support Grant (FSG), Semi-Independent Living Services grants, Day Training grants, Epilepsy grants, Self-advocacy grants, Disability Linkage Line; and Transition, Employment and Modify Residency Ratios grants.
- Aging grant programs: Caregiver Support Grant, SAIL grants, Prescription Drug Assistance, Senior Nutrition Program, Community Services and Service Development, Senior LinkAge Line, Senior Volunteer Program, Return to Community, Aging LTCC, Core Service grants, Preadmission Screening.
- Deaf and Hard of Hearing grants.

Services not included in the proposal are: Nursing facilities; non-direct service disability grants; non-direct service aging grants (such as Aging and Adult Service gaps analysis grant); children's mental health CTSS & day treatment; adult mental health services; chemical dependency treatment services; and therapies.

Providers will receive a 4% increase to their rates on July 1, 2014. 75% of this rate increase must go towards worker pay and benefits. To maintain the full 4%, providers will need to complete a one-page online form in which they document a quality improvement effort that they will undertake. If a provider fails to complete and submit this form to DHS by a deadline provided by the Commissioner, 1% will be removed from their rates effective January 1, 2015. This proposal includes time-limited administrative resources for the Department to effectively manage the provider submissions and ensure that all rate adjustments are applied accurately.

Personal care assistance providers, Community First Services and Supports providers, disability grants, aging grants, and deaf and hard of hearing grants will not be required to submit the form and will receive the full 4% rate increase.

In line with the goals of the HCBS Performance-Based Incentive Payment Program, we will look for providers to commit to a quality improvement effort that aligns with one of these three goals: 1) Improve the quality of life of home and community-based services participants in a measurable way; 2) Improve the quality of services in a measurable way; and 3) Deliver good quality service more efficiently. Special emphasis will be placed on undertaking quality improvement efforts related to person-centered service delivery, cultural competency and retention of staff.

MN.IT Services Impacts from Proposal:

There are no MN.IT impacts associated with implementation of this proposal.

Performance Measures:

This proposal will be successful if usage of HCBS increases within the state as evidenced by (1) the percent of long-term care participants receiving HCBS and (2) if HCBS providers are undertaking quality improvement efforts that align with one of the three stated goals as measured by the percentage of HCBS providers required to submit a quality improvement form who do so by the deadline.

Statutory Change: M.S. §256B.501; uncodified rate increase

Statewide Outcome: This proposal primarily supports the following statewide outcome:

	Health: All Minnesotans have optimal health
X	Community: Strong and stable families and communities
	Safety: People in Minnesota are safe
	Education: Minnesotans have the education and skills needed to achieve their goals
	Government: Efficient and accountable government services

DHS Fiscal Detail for Budget Tracking

Net Impact by Fund ($000s)			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
General Fund			$ -	$ 64,322	$ 74,698	$ 79,529
Health Care Access Fund						
Other Fund (specify)						
Total All Funds			**$ -**	**$ 64,322**	**$ 74,698**	**$ 79,529**
Budget Detail			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Fund	BACT	Description				
GF	33	MA Grants - LW	-	50,483	57,042	61,458
GF	33	MA Grants - LF	-	3,116	3,381	3,370
GF	33	MA Grants - ED	-	7,905	10,836	11,275
GF	33	MA Grants - FC	-	6	6	7
GF	34	Alternative Care, ECS	-	772	1,033	1,064
GF	55	Disability Grants	-	1,015	1,239	1,248
GF	54	Deaf & Hard of Hearing Grants	-	66	72	72
GF	53	Aging & Adult Services Grants	-	829	1,024	1,035
GF	14	CCA Admin	-	200	100	-
REV1		Admin FFP	-	(70)	(35)	
FTEs Requested						
GF	14	CCA Admin		2.00	1.00	

Change Item Title: HCBS PIPP & Quality Add-On Correction

Fiscal Impact ($000s)	FY 2014	FY 2015	FY 2016	FY 2017
General Fund				
Expenditures	(15)	(74)	281	812
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	(15)	(74)	281	812

Recommendation:

Effective February 1, 2014, the Governor recommends: 1) adding home care providers to the list of providers eligible for the Home and Community-Based Services (HCBS) Performance-based Incentive Payment Program (PIPP) and Quality Add-On rate increases; 2) changing the appropriation of funds for the HCBS Quality Add-On from a fixed dollar amount to a fixed percent of forecasted expenditures; and, 3) correcting an error in the appropriation for the Essential Community Supports (ECS) program. This recommendation has a fiscal impact of $15,000 in savings in FY 2014 and $74,000 in savings in FY 2015.

Rationale/Background:

The 2013 Minnesota Legislature enacted a general rate increase for providers of long term care Home and Community-Based Services (HCBS), as well as a rate increase and grant program tied to provider quality. Home care providers were inadvertently missed from the list of providers who are eligible for the HCBS Performance-based Incentive Payment Program (PIPP) and the HCBS quality add-on. The final 2013 HHS Omnibus tracking spreadsheet did include funding for home care providers, since the legislative intent was that these providers be included in these pay-for-quality programs, which were created to give incentives for all HCBS providers to provide quality care. Since the Department is interested in encouraging and providing incentives to providers to meet quality outcomes and it is important that this incentive exist in both the HCBS waiver and home care provider industries, this proposal corrects the error and makes application of this quality initiative consistent across the long term service and support provider spectrum.

The 2013 legislature transferred the former Essential Community Supports (ECS) program from the Aging & Adult Services Grants budget activity into the forecasted Alternative Care budget activity. A separate action provided a 1% rate increase effective April 1, 2014 to Home and Community-based Services (including ECS). The funding for the 1% increase was appropriated to Aging & Adult Services Grants budget activity rather than to the Alternative Care budget activity where the program's base funding now resides. The February 2014 forecast accounts for the full value of Alternative Care program, including the portion of rate increases attributable to the former ECS program. However, since Aging & Adult Services Grants are not forecasted, separate action is needed to remove the 1% amount from the Aging Grants account.

Proposal:

This proposal adds home care providers to the list of HCBS providers eligible for the PIPP and Quality Add-On rate increase. This proposal corrects the language to match the fiscal tracking and original intent. The PIPP program begins April 1, 2014. The quality add-on does not begin until July 1, 2015. This change is effective retroactively to February 1, 2014.

This proposal also amends the HCBS quality add-on rate increase to specify that it is equal to the average value of a 1% rate increase. The way the quality add-on was described in the 2013 enacting provision is not consistent with how DHS had arrived at the cost estimate for the initiative, and would be difficult for the Department to incorporate into the DHS forecast. Under this proposal DHS will instead be able to account for the cost of the quality add-on as originally intended.

Lastly, this proposal removes the 1% rate increase for the ECS program from the Aging & Adult Services budget activity. The February forecast correctly accounts for the value of the increased funding in the Alternative Care budget activity.

MN.IT Services Impacts from Proposal:

There are no MN.IT impacts associated with implementation of this proposal.

Performance Measures:

The HCBS Pay for Performance Initiative will inform quality measurement of services provided to older adults and people with disabilities. The PIPP program allows HCBS providers to apply for funding for specific quality improvement projects. Providers will identify their own measures, specific to the PIPP projects they propose. These will inform the measures used for the HCBS quality add-on.

Statutory Change: M.S. §256B.439; amendments to Laws 2013, chapter 108, article 14, section 2.

Statewide Outcome: This proposal primarily supports the following statewide outcome:

X	Health: All Minnesotans have optimal health
	Community: Strong and stable families and communities
	Safety: People in Minnesota are safe
	Education: Minnesotans have the education and skills needed to achieve their goals
	Government: Efficient and accountable government services

DHS Fiscal Detail for Budget Tracking

Net Impact by Fund ($000s)			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
General Fund			$ (15)	$ (74)	$ 281	$ 812
Health Care Access Fund						
Other Fund (specify)						
Total All Funds			**$ (15)**	**$ (74)**	**$ 281**	**$ 812**
Budget Detail			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Fund	BACT	Description				
GF	33	MA Grants LW: remove 2013 legislative capped amount	-	-	(16,878)	(18,993)
GF	33	MA Grants LW: replace with forecasted 1% equivalent quality add-on			16,569	19,116
GF	33	MA Grants LW: interaction with 4% HCBS rate increase			663	763
GF	53	Aging Grants - ECS Correction	(15)	(74)	(73)	(74)
FTEs Requested						

Change Item Title: Community First Services and Supports Policy & Program Integrity Changes

Fiscal Impact ($000s)	FY 2014	FY 2015	FY 2016	FY 2017
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0

Recommendation:

Effective July 1, 2014, the Governor recommends makes statutory changes to Minnesota Statutes 256B.85 "Community First Services and Supports" that include: a) authority to establish a payment rate methodology for consultation and financial management services; b) policy changes related to who can work as a direct support worker; and c) language changes to reflect service design and policy decisions for service standards, service delivery, and program integrity. These proposed changes include recommendations from a November 2013 legislative report related to CFSS program integrity. This proposal is budget neutral.

Rationale/Background:

Legislation passed in the 2013 session establishes the new Community First Services and Supports (CFSS) option effective April 1, 2014 or upon federal approval, whichever is later. CFSS will replace the Personal Care Assistance (PCA) program and the Consumer Support Grant. CFSS offers assistance with daily living, health-related tasks and skills acquisition; assistive technology; environmental modifications; and other supports required by individuals with functional needs to sustain community living.

Proposal:

This proposal makes the following changes to CFSS:

Payment Option for Consultation and Financial Management Services: This change creates a payment methodology for Consultation and Financial Management Services for all CFSS participants. In the CFSS program, CMS requires that Consultation and Financial Management Services be available. All CFSS participants, whether they are using an agency or directing their own services through the budget model, will have access to Consultation Services. Those choosing the budget model will also use a Financial Management Service to do things like manage payroll and pay taxes for the support workers providing the service. Participants use Consultation Services to decide if they want to self-direct their care under CFSS. If they decide not to choose the budget model, then participants select a CFSS provider agency that delivers the authorized units of service. If the recipient decides to direct their own services, the Consultation Services provider helps the recipient set up a personalized plan, including access to Financial Management Services. The recipient decides what kinds of help a support worker will provide for them and how much they will pay the worker out of their budget, and the worker delivers the care. This proposal is budget neutral because the new services will be included in current projected expenditures for the MA program.

Policy changes related to who can work as a direct support worker: This change allows parents of minors and spouses to be paid as direct support workers. This is consistent with policy and practice under Minnesota's other self-directed programs: Consumer Directed Community Support and the Consumer Support Grant. The same limits that apply to parents of minors and spouses in those programs will also apply in the CFSS program.

Service design and policy decisions for service standards, service delivery, and program integrity:
1) Establishing billing requirements for CFSS: These provisions include individual enrollment and each caregiver being specified on the billing claim line; minimal time sheet requirements such as time in and time out; and time limits on the amount of hours allowed.
2) Limiting the number of hours that a caregiver can bill for and be paid: The proposal establishes a limit of not working more than 24 hours a day and a limit of 275 hours/month.
3) Clarifying: who is financially liable for any overpayments or violations of applicable rules, regulations and statutes regarding CFSS.
4) Adding several provisions: regarding background study requirements for the CFSS program. While the current CFSS program contains some background study provisions, there are several key factors that need to be

addressed. The added provisions include information on who needs to request a background study and the requirement that a clearance letter must be received prior to starting any service.

MN.IT Services Impacts from Proposal:
There are no MN.IT impacts associated with implementation of this proposal.

Performance Measures:

Reforming the PCA program and testing new models of service coordination will make these services more accessible and flexible, and will facilitate transition out of institutional care and prevent or delay future admissions. Key indicators to measure success include the percent of Long Term Care recipients and Home and Community Based Services recipients served at home.

Statutory Change: M.S. §256B.85, 245C.

Statewide Outcome: This proposal primarily supports the following statewide outcome:

	Health: All Minnesotans have optimal health
X	Community: Strong and stable families and communities
	Safety: People in Minnesota are safe
	Education: Minnesotans have the education and skills needed to achieve their goals
	Government: Efficient and accountable government services

DHS Fiscal Detail for Budget Tracking

Net Impact by Fund ($000s)			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
General Fund			$ -	$ -	$ -	$ -
Health Care Access Fund						
Other Fund						
Total All Funds			**$ -**	**$ -**	**$ -**	**$ -**
Budget Detail			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Fund	BACT	Description				
GF	33	MA Grants - LW	$ 348	$ 7,267	$ 9,517	$ 9,893
GF	33	MA Grants - LW	$ (348)	$ (7,267)	$ (9,517)	$ (9,893)
FTEs Requested						

Change Item Title: Jensen Settlement Compliance

Fiscal Impact ($000s)	FY 2014	FY 2015	FY 2016	FY 2017
General Fund				
Expenditures	0	1,400	1,834	1,826
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	1,400	1,834	1,826

Recommendation:

Effective July 1, 2014, the Governor recommends increased funding to meet the timelines and action items required in the February 12, 2014 Jensen Comprehensive Plan of Action regarding: 1.) the closure and replacement of the MSHS-Cambridge facility with community services and 2.) the modernization of Rule 40. This proposal invests $1.4 million in FY2015 and $3.7 million in the FY2016-17 biennium.

Rationale/Background:

On December 5, 2011, the United State District Court for the District of Minnesota adopted the settlement agreement in the Jensen class action. The goal of the settlement was to improve the care and treatment of individuals with developmental and other disabilities in the state. On February 12, 2014, the final Comprehensive Plan of Action (CPA) was released and this recommendation is intended to meet the requirements included in the CPA.

Part I of the CPA relates to the MSHS-Cambridge facility. DHS State Operated Services is required, based on the Jensen settlement agreement Comprehensive Plan of Action item number 98, to "…maintain therapeutic follow-up of Class Members, and clients discharged from METO/MSHS-Cambridge since May 1, 2011, by professional staff to provide a safety network, as needed, to help prevent re-institutionalization and other transfers to more restrictive settings, and to maintain the most integrated setting for those individuals."

Part 2 of the CPA relates to the modernization of Rule 40. The Department must implement a plan agreed to under the Jensen settlement for the modernization of Rule 40, which will incorporate many of the recommendations of the Rule 40 Advisory Committee and consultants. Rule 40 governs the use of aversive and deprivation procedures in licensed facilities that serve people with developmental disabilities. Modernization of Rule 40 includes transitioning to current best practices when providing services to all individuals with disabilities. These include the use of positive social and behavioral supports, prohibitions on the use of restraints and seclusion, trauma informed care and development of community support plans that are consistent with person centered planning.

Proposal:

As part of the requirements of the CPA, DHS must monitor and follow 390 Cambridge facility clients in their community placement. To do this, State Operated Services (SOS) is requesting additional administrative resources of 7.0 FTEs in FY15. These staff are needed to provide on-going monitoring and support through site visits and training of service providers to assure clients can be served in the least restrictive setting. In FY16, an additional 2.0 FTEs are requested to assist with administrative oversight and to staff the Jensen Implementation, Compliance and Quality Assurance office, thus assuring implementation of the items in the Jensen settlement agreement.

In addition, to address the Rule 40 modernization, this proposal requests 5 FTEs and other administrative resources in FY15 for the Continuing Care Administration to:

- Implement the rulemaking process;
- Provide client-specific technical assistance and training to lead agencies and providers by trained people with experience in positive support practices;
- Develop capacity of trained clinicians in the areas of positive support practices;
- Develop training curriculum and manuals on positive support practices;
- Build in-state training capacity for person centered planning;
- Develop lead agency protocol, sampling strategies and incorporate into waiver review field-based activities;
- Make technical and conforming changes to M.S. Chapter 245D, where Jensen compliance statute is located.

Resources are also needed for training and technical assistance on positive support practices and person-centered planning to help build capacity of providers in the community to appropriately support people, to reduce the number of re-hospitalizations and use of emergency rooms, to avert crises of individuals, to ensure there are appropriate and needed services in the community to meet the diverse needs of people. These efforts work to fulfill the requirement of the Jensen Settlement by satisfying the court monitoring of related implementation plans

MN.IT Services Impacts from Proposal:
Systems maintenance and report development in SSIS to expand the Statewide Common Entry Point to receive maltreatment and behavior reports are included in this proposal.

Performance Measures:

This proposal will be successful according to the following measures:

- % of Positive Support Transition Plans that are phased out;
- Reduce the number of incidents including emergency use of manual restraint; and
- Decrease the number of persons receiving 10 or more psychotropic medications concurrently.

Statutory Change: Provisions in Chapter 245D

Statewide Outcome: This proposal primarily supports the following statewide outcome:

	Health: All Minnesotans have optimal health
X	Community: Strong and stable families and communities
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	Education: Minnesotans have the education and skills needed to achieve their goals
	Government: Efficient and accountable government services

DHS Fiscal Detail for Budget Tracking

Net Impact by Fund ($000s)			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
General Fund			$ -	$ 1,400	$ 1,834	$ 1,826
Health Care Access Fund						
Other Fund (specify)						
Total All Funds			**$ -**	**$ 1,400**	**$ 1,834**	**$ 1,826**
Budget Detail			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Fund	BACT	Description				
GF	14	Rulemaking	-	88	12	
GF	14	CCA admin (FTEs 0, 3.75, 5, 5)	-	463	578	578
GF	14	CCA admin contracts/non-salary	-	225	525	525
REV1		Admin FFP	-	(272)	(390)	(386)
GF	61	SOS Mental Health (FTEs 0, 6.25, 9, 9)	-	846	1,059	1,059
GF	11	TRO Operations (SSIS)	-	50	50	50
DED	11	TRI Operations (SSIS)	-	(50)	(50)	(50)
DED	11	Exp Operations (SSIS)	-	50	50	50
FTEs Requested						
GF	14	CCA Admin		3.75	5.00	5.00
GF	61	SOS Mental Health		6.25	9.00	9.00

Change Item Title: Northstar Technical and Fiscal

Fiscal Impact ($000s)	FY 2014	FY 2015	FY 2016	FY 2017
General Fund				
Expenditures	0	(3)	(3)	6
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	(3)	(3)	6

Recommendation:

The Governor recommends several technical changes to the Northstar Care for Children provisions in Minnesota statutes effective January 1, 2015, to ensure federal compliance and efficient administration of the new program.

Rationale/Background:

The 2013 Legislature passed Northstar Care for Children (M.S. Chapter 256N), designed to reduce the length of time that children spend in foster care and increase the likelihood that those who cannot be reunified with their original families acquire new permanent families rather than aging out of foster care.

Effective January 1, 2015, Northstar Care for Children provides for the consolidation and simplification of foster care, kinship care, and adoption assistance into a single program. Central features include a single assessment process, unification of benefits and procedures, and uniform benefits for children age 6 and over, to eliminate the discrepancies in benefits between foster care on one end of the spectrum and adoption and transfers of legal custody on the other.

Northstar Care for Children will bring in considerable new federal funding under Title IV-E of the Social Security Act, with state, county, and tribal funds providing the match. Title IV-E supports all three components (foster care, kinship care, and adoption assistance). Federal kinship assistance is a recent federal option and this will be the first time it has been used in Minnesota. The key changes in this proposal involve compliance with federal Title IV-E regulations for kinship guardianship assistance.

Proposal:

Effective January 1, 2015, the following changes are proposed:

1. **Clarify the background study requirements** in M.S.§ 245C for federal Title IV-E eligibility for the kinship guardianship assistance component and streamline requirements where existing background studies and other foster care processes can meet the same purpose. This would streamline the background and home study processes requirements at permanency placement that have been previously completed as part of the child foster care licensing, eliminating duplication and delays for a child to be adopted by their foster parent. There are background study changes for two groups:

- Foster parents who are moving to adopt will no longer need a new background study.
- Some relatives will require a new background study: relatives with whom a child has been placed and who are pursuing child foster care licensure; and relatives to whom permanent legal custody is transferred and who will not seek child foster care licensure

These are Adam Walsh background studies which are funded under a state appropriation that is not dependent on the number of studies done, therefore the change in the number of studies estimated to be done under this proposal is budget neutral.

2. **Streamline the payment process** to counties for Relative Custody Assistance (RCA) program once Northstar Care for Children starts January 1, 2015. Under current law, the department would be required to first pay counties 100% of their RCA expenditures each quarter, and then bill them for their county share. Eliminating this extra step would streamline the process for both counties and the department, avoiding unnecessary computer programming to achieve the same fiscal outcome. This change is technical only – no fiscal impact.

3. **Amend M.S. Chapter 256N**, the Northstar Care for Children Act, to specify that the child needs to have lived with the prospective relative custodian for a minimum of six consecutive months (already in the language) after the custodian has been licensed for foster care (to be added). Previous federal publications had been clear that the child must be placed with the prospective relative custodian for a minimum of six months, but were unclear about the requirement that the prospective relative custodian had to be fully licensed for the entire six months; this was recently clarified. There is a small cost of $2,000 in SFY 2015, $8,000 in SFY 2016 and $17,000 in SFY 2017 due to this additional requirement.

4. **Eliminate provisions** passed in 2013 that required a special needs determination for the kinship guardianship assistance component of Northstar and a $1 per month nominal payment for kinship guardianship and adoption assistance payments.

A special needs determination is not required for kinship guardianship. If this determination had been needed, federal regulations would require that a nominal monthly payment, in this case the $1/ month payment, be made to retain Title IV-E eligibility for kinship guardianship assistance. Provisions were included last session to keep adoption assistance in alignment with this $1/month payment. This $1/month payment is not required to retain Title IV-E eligibility for kinship guardianship and is not a federal requirement for the adoption assistance component. Elimination of the $1/month payment will result in small savings of $5,000 in SFY 2015 and $11,000 per year ongoing to the adoption assistance component of Northstar. There is no fiscal impact to the kinship guardianship component, since no children would have been eligible based on the special needs determination.

MN.IT Services Impacts from Proposal:

There are no MN.IT impacts associated with implementation of this proposal.

Performance Measures:

Implementation of Northstar Care would reduce the number of children in out-of-home care; reduce the length of stay in out-of-home care; and, increase the percent of children adopted within 24 months of entry in foster care.

Statutory Change: M.S. §§ 252.27, 256B.055, 257.85, 609B.445, and provisions in M.S. chapters 245A, 245C, 256N, 259, and 260C.

Statewide Outcome: This proposal primarily supports the following statewide outcome:

	Health: All Minnesotans have optimal health
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DHS Fiscal Detail for Budget Tracking

Net Impact by Fund ($000s)			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
General Fund			$ -	$ (3)	$ (3)	$ 6
Health Care Access Fund						
Other Fund (specify)						
Total All Funds			**$ -**	**$ (3)**	**$ (3)**	**$ 6**
Budget Detail			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Fund	BACT	Description				
GF	45	Children's Services Grants-Northstar Care	-	(3)	(3)	6
FTEs Requested						

Change Item Title: Health Care Payment Modernization

Fiscal Impact ($000s)	FY 2014	FY 2015	FY 2016	FY 2017
General Fund				
Expenditures	$ -	$ -	$ -	$ -
Revenues				
Net Fiscal Impact = (Expenditures – Revenues)	$ 0	$ 0	$ 0	$ 0

Recommendation:

The Governor recommends several changes to modernize health care payment practices at the Minnesota Department of Human Services (DHS). Two of the recommended changes, upgrading to the tenth edition of the International Classification of Diseases Clinical Modification (ICD-10) and the requirement that hospitals receiving disproportionate share funding submit annual audit reports, are required to ensure federal compliance. As a necessary component of changes needed to incorporate ICD-10, a cost neutral rebasing of hospital inpatient rates is also proposed. The final recommendation would reduce reprocessing of claims submitted by Federally Qualified Health Centers and Rural Health Centers. While the recommended changes affect the inpatient hospital rate structure and other financial activities of the state's publicly-funded health care programs, this proposal is budget neutral.

Rationale/Background:

ICD-10:

Effective October 1, 2014 the federal Centers for Medicare and Medicaid Services (CMS) have mandated that all payers use ICD-10-CM diagnoses and procedure codes for inpatient hospital claims. Minnesota Health Care Programs (MHCP) current inpatient hospital payment methodology is based on Diagnosis Related Groups (DRGs) which are assigned using the ninth edition of the International Classification of Diseases Clinical Modification (ICD-9-CM) diagnosis and procedure codes. The current software used at DHS will be unable to properly group inpatient claims because they will contain the updated ICD-10-CM diagnosis and procedure codes. This will result in claims submitted with a discharge date after October 1, 2014 being denied for payment.

Rebasing Hospital Rates:

Rebasing hospital payment rates modernizes the rate structure, recognizing factors that change the use of hospital resources over time. These factors can include changes to patient case mixes, hospital treatment patterns and the use of medical technology. Historically, MHCP were required by statute to rebase hospital rates every two years. MHCP fee for service hospital rates were last rebased in 2007. This proposal rebases hospital rates effective September 1, 2014 to ensure that rates accurately reflect the current use of hospital resources. Rebasing rates to reflect more current hospital practices and case mixes ensures that the add on for disproportionate share hospital payments is correctly calculated, and that hospitals can remain under federal upper payment limits. Updating the payment methodology also ensures that MHCP remain consistent with other payers in the marketplace.

Inpatient Hospital Cost Reports:

Federal law requires state Medicaid programs to make disproportionate share (DSH) payments to hospitals treating a large number of low income patients to help pay for uncompensated care. Minnesota has 104 hospitals that qualify as "Disproportionate Share Hospitals," or DSH. These hospitals receive approximately $76 million in federal DSH funding annually. DHS distributes DSH funds to designated hospitals through an add-on to the inpatient hospital rate in accordance with federal guidance and state law.

Recently published federal rules require states to collect Medicare cost report data from hospitals receiving DSH beginning with the 2014 audit submission. The rule further suggests that there will be a reduction in federal DSH funding allotments to states who fail to submit for certification the DSH audit report numbers on DSH hospitals. Currently, about 1/3 of the 104 DSH hospitals do not submit their audit reports to DHS. If the reporting requirements are not updated in state law it may result in a loss of DSH funds to Minnesota.

FQHC and RHC:

Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) receive payments based on trended costs from 1999-2000 plus inflation. Current payment processes for MHCP allow these providers to resubmit claims for reprocessing, requesting inflationary adjustments as well as adjustments based on the increases or decreases in the scope of services provided, which can include a change in type, intensity and duration of

services. Presently, DHS does not have a restriction on how far back these adjustments can be submitted and reprocessed.

Proposal:

ICD-10:

This proposal would move DHS from ICD-9 to ICD-10 in order to comply with federal requirements. To maintain timely payment of inpatient claims, DHS proposes payments based on the Medicare Inpatient Prospective Payment System (IPPPS), utilizing the All Patient Refined DRG grouped (APRDRG) for all inpatient claims effective September 1, 2014. This established prospective payment methodology is compatible with both the ICD-9 and ICD-10 diagnosis and procedure codes and is used by other Medicaid programs across the country. This change is needed to avoid denial of inpatient hospital claims.

Rebasing Hospital Rates:

Inpatient hospital rates are set based on average hospital specific costs from a base year. Payment rates are then adjusted by a diagnosis related group (DRG) grouping factor that reflects the cost of treating specific diagnoses. Under this proposal, MHCP will rebase rates using submitted hospital charges adjusted by cost ratios to update the relative values and the case mix indices using updated grouping software and applying an aggregate rate reduction for budget neutrality. This proposal will also clarify the hospital payment rate structure by consolidating all the current ratable reductions in statute and eliminating outdated language. Critical access hospitals as defined under MS § 144.55 are exempt from this proposal and will be reimbursed on a cost basis adjusted for budget neutrality.

Converting DHS payment systems to accept and properly adjudicate claims containing ICD-10 codes requires the use of a new grouper to properly classify hospital services and assign the correct rates. Updating the hospital payment grouper rebases hospital rates, and a new ICD-10 compliant grouping system cannot utilize the logic used to group hospital services under ICD-9 codes. As hospital rates are based on diagnostic groupings, it is not possible to precisely replicate the current hospital payment structure that groups hospital claims containing ICD-9 coding when grouping claims containing ICD-10 codes. Moreover, the current rates are based on 2002 hospital costs and a rebasing involving such outdated cost information will result in rates that lack statistical validity.

Under this proposal, DHS will rebase the hospital rates utilizing new software capable of grouping claims containing ICD-10 codes. DHS will work with stakeholder provider groups on strategies to carefully track the outcomes by comparing hospital claims data paid under the current grouper and ICD-9 coding system with those paid using APRDRG and the ICD-10 coding system.

Inpatient Hospital Cost Reports:

Effective July of 2014, this proposal requires all hospitals who receive DSH funding to submit their audit reports. Hospitals who elect not to participate in this reporting requirement would no longer receive the DSH add-on to the Medical Assistance inpatient hospital rate.

FQHC and RHC:

This proposal streamlines the payment of of claims to Federally Qualified Health Centers and Rural Health Centers by establishing an annual close out process effective July 1, 2014. In July of each year, DHS would provide a close out document providing the opportunity to review claims for final reprocessing of claims received during the previous two years to all FQHC and RHC providers, to which they would respond. Once an agreement is reached on the close out document, DHS would no longer reprocess those claims. In the event that an agreement cannot be reached, the case would go to an arbitrator for final action.

MN.IT Services Impacts from Proposal:

There are some small MMIS costs relating to updating the grouper software in order to rebase hospital rates. The funds for these changes are already budgeted within the DHS systems fund.

The ICD-10 project will include an extensive review of MMIS edits to determine the changes needed to pay claims both under the ICD-9 diagnosis codes and the ICD-10 codes. Systems resources had previously been budgeted for the ICD-10 project. Once completed, systems staff will conduct code changes and testing to ensure correct claims payment.

Limiting the time period for submission of FQHC and RUC claims will reduce the amount of claims reprocessing through the MMIS systems.

Performance Measures:

This proposal reforms MHCP payment systems and policies, making them consistent with that of other healthcare payers in the market while simplifying claims payment processes for FQHC and RHC providers. Rebasing hospital rates helps align Minnesota's public health care expendatures and the use of provider resources needed to treat Minnesota Helath Care Program reciepients.

Statutory Change:
Minnesota Statutes § 256.969

Statewide Outcome: This proposal primarily supports the following statewide outcome:

X	Health: All Minnesotans have optimal health
	Community: Strong and stable families and communities
	Safety: People in Minnesota are safe
	Education: Minnesotans have the education and skills needed to achieve their goals
	Government: Efficient and accountable government services

DHS Fiscal Detail for Budget Tracking

Net Impact by Fund ($000s)			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
General Fund						
Health Care Access Fund						
Other Fund (specify)						
Total All Funds			**$ -**			
Budget Detail			**FY 2014**			
Fund	BACT	Description				
FTEs Requested						

Change Item Title: Community Addiction Recovery Enterprise Deficiency Funding Request

Fiscal Impact ($000s)	FY 2014	FY 2015	FY 2016	FY 2017
General Fund				
Expenditures	$1,000	$1,000	$ 0	$ 0
Revenues	0	0	0	0
Enterprise Fund				
Expenditures	4,000	4,000	0	0
Revenues			0	0
Net Fiscal Impact = (Expenditures – Revenues)	$5,000	$5,000	$ 0	$ 0

Recommendation:

The Governor recommends providing operating funds for fiscal years 2014 and 2015 to the state-operated Community Addiction Recovery Enterprise (C.A.R.E.) by transferring $4,000,000 per year from an existing account with the Department of Human Services and providing one-time general fund appropriation of $1,000,000 per year. Projections based on current rates and program volumes reflect a projected operating deficiency of $5,000,000 per fiscal year.

Rationale/Background:

The state-operated Community Addiction Recovery Enterprise (C.A.R.E.) primarily serves individuals who are committed to the Commissioner of Human Services and that have complex needs that cannot be served by other providers. C.A.R.E. operates under an enterprise fund and is required to support itself through the collections received from billed services. The cost to provide the services needed by this population exceed the available reimbursement and has completely depleted the cash for the program. The program is currently operating on negative cash authority in order pay for the costs of the program and will need to be able to balance at the end of each fiscal year by repaying any negative cash authority that has been used during the fiscal years.

The primary payer for C.A.R.E. is the Consolidated Chemical Dependency Treatment Fund (CCDTF). The current rate structure under CCDTF does not recognize the need or cost for higher staffing levels required for individuals in secure residential settings who have complex conditions or for the higher costs of a state-operated service. The Department of Human Services Alcohol and Drug Abuse Division (ADAD) is reviewing the current rates structure for services paid for under the fund and the need for rate adjustments. ADAD plans to complete this review during FY2014 and prepare a rate adjustment proposal for inclusion in the 2015 session. It is anticipated that any rate adjustment made to the current CCDTF rates will still be insufficient to accommodate the higher cost for the complex population served by C.A.R.E and support the operation of the program.

For fiscal year 2013, the program received a one-time transfer of existing one-time funds from Consolidated Chemical Dependency Fund administrative funds available in the special revenue fund.

Proposal:

For fiscal years 2014 and 2015, the program will again require one-time transfers of $4,000,000 from the Consolidated Chemical Dependency Fund (CCDTF) administrative funds available in the special revenue fund and providing $1,000,000 of general fund appropriation each year. The initial transfer of funds will need to be available prior to the close of fiscal year 2014 to assure the fund is in balance for the close of the fiscal year.

The transfer of the CCDTF administrative funds will be limited to the fiscal years identified and to the availability of funds not required to administer the operation of the CCDTF. During the period of time for which these funds are available, the agency will develop and seek federal approval of a payment methodology that will support the costs and maintain the operations of the state-operated addiction programs.

MN.IT Services Impacts from Proposal:

There are no MN.IT impacts associated with implementation of this proposal.

Performance Measures:

This is a one-time request to bring the fund into balance.

Statutory Change: MS § 254B.12, rider

Statewide Outcome: This proposal primarily supports the following statewide outcome:

X	Health: All Minnesotans have optimal health
	Community: Strong and stable families and communities
	Safety: People in Minnesota are safe
	Education: Minnesotans have the education and skills needed to achieve their goals
	Government: Efficient and accountable government services

DHS Fiscal Detail for Budget Tracking

Net Impact by Fund ($000s)			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
General Fund			$1,000	$1,000		
CARE EnterpriseFund (4101)						
Special Revenue Fund Fund (2000)			$4,000	$4,000		
Total All Funds			**$5,000**	**$5,000**		
Budget Detail			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Fund	BACT	Description				
1000	62	C.A.R.E. direct appropriation	1,000	1,000		
2000	15	CD Policy Admin - Transfer out	4,000	4,000		
4101	62	C.A.R.E. - Transfer in	(4,000)	(4,000)		
4101	62	C.A.R.E. - Expenditure	4,000	4,000		
FTEs Requested						

Change Item Title: Andrew Residence Rate Adjustment

Fiscal Impact ($000s)	FY 2014	FY 2015	FY 2016	FY 2017
General Fund				
Expenditures	0	681	697	715
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	681	697	715

Recommendation:

The Governor recommends that the current rate paid under the Group Residential Housing program (GRH) to a residence that, as of August 1, 1984, was licensed by the commissioner of health only as a boarding care home, that is certified by the commissioner of health as an intermediate care facility and licensed by the commissioner of human services under Minnesota Rules, parts 9520.0500 to 9520.0690, be codified in state law. The recommended change will require appropriations above the current forecast of $681,000 in SFY 2015 and $1,412,000 in the 2016-17 biennium.

Rationale/Background:

Andrew Residence is a unique facility in Minneapolis that serves over 200 people with serious and persistent mental illness who also need a nursing home level of care. Many of the residents are civilly committed to the facility. This is the only facility of its kind in Minnesota and, due to its size and client population, the facility is not eligible to receive Medicaid reimbursement for most of the clients.

A recent review of current rates paid to Andrew Residence found that they do not align with requirements in statute. The rates required under law are not sufficient to support the level of services provided in the facility and the recommended change is needed to maintain the level of care currently offered in the program. To improve program integrity and ensure that rates continue to fully support the services provided in this unique facility, this recommendation would codify the current rate calculation.

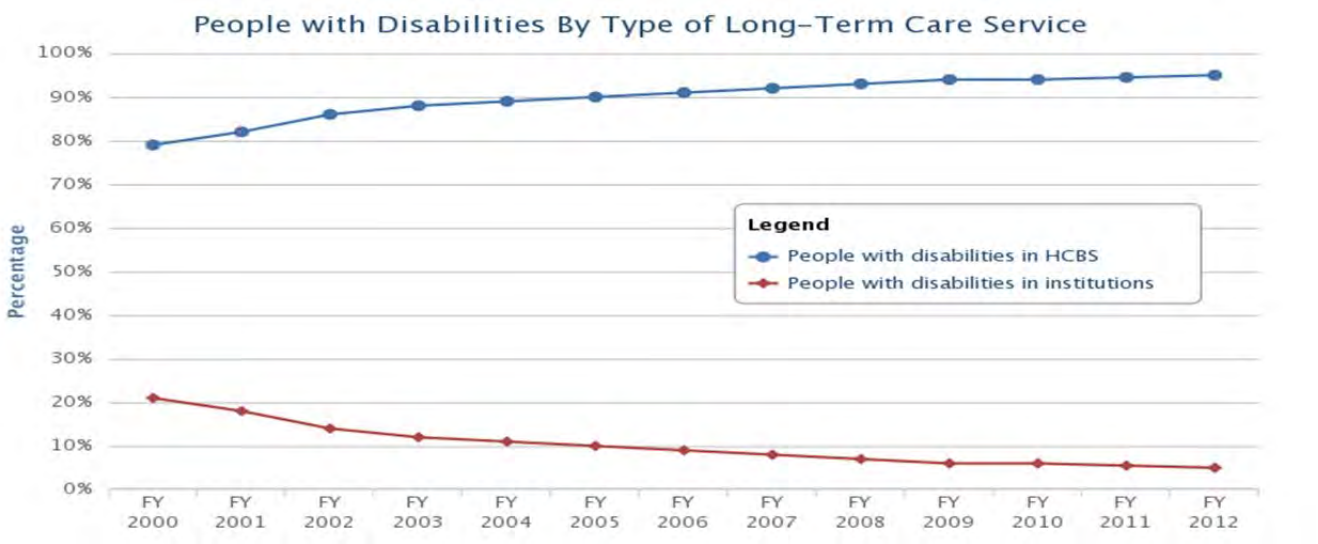
Proposal:

Effective July 1, 2014, revise the GRH statute to align it with the current rates paid for this facility, which are based on nursing facility payment rates and include adjustments made to the general GRH housing rate and adjustments to supplemental service rates. Continuation of these current rates will allow Andrew Residence to continue to provide services for its unique clients.

MN.IT Services Impacts from Proposal:

There are no MN.IT impacts associated with implementation of this proposal.

Performance Measures:



Measure:
The percentage of People with Disabilities by type of Long Term Care: Institutions vs. Home and Community Based Services (HCBS).

Goal:
Increase the percentage of people served in their homes and communities rather than in institutions.

Andrew Residence provides specialized health services to persons with serious and persistent mental illness who require 24-hour supervision and care. Without this care, persons living in this facility would be at an increased risk of homelessness or higher level of institutionalization. This budget change item will enable up to 250 people per year to receive the care they need to avoid homelessness, higher levels of institutionalization, and a decrease in health.

Statutory Change: M.S. 256I.05, subdivision 2.

Statewide Outcome: This proposal primarily supports the following statewide outcome:

X	Health: All Minnesotans have optimal health
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	Education: Minnesotans have the education and skills needed to achieve their goals
	Government: Efficient and accountable government services

DHS Fiscal Detail for Budget Tracking

Net Impact by Fund ($000s)			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
General Fund			$ -	$ 681	$ 697	$ 715
Health Care Access Fund						
Other Fund (specify)						
Total All Funds			**$ -**	**$ 681**	**$ 697**	**$ 715**
Budget Detail			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Fund	BACT	Description				
GF	25	Group Residential Housing	-	681	697	715
FTEs Requested						

Change Item Title: Coordination of Benefits Project

Fiscal Impact ($000s)	FY 2014	FY 2015	FY 2016	FY 2017
General Fund				
Expenditures		$ 81	$ 148	$ 148
Revenues		$ (175)	$ (350)	$ (357)
Net Fiscal Impact = (Expenditures – Revenues)		$ (94)	$ (202)	$ (209)

Recommendation:

The Governor recommends participation in the national Council of Affordable Quality Healthcare (CAQH) Coordination of Benefits (COB) Project starting July 1, 2014. Participation would improve third party recoveries and give providers a central location for locating coverage information. Participation in this project enables providers to better identify primary and secondary insurance coverage submitted by participating insurers nationwide. Access to the COB system will enable providers to reduce paperwork, streamline payment processes, and increase accurate payments. It is expected that participation in this project will result in increased recovery activities, producing General Fund savings of $94,000 in FY15 and of $411,000 for the FY 2016-17 biennium.

Rationale/Background:

Health care payers and providers often struggle to identify and assess payer responsibilities where patients have coverage from multiple insurers. Reliable and up to date information regarding the correct order of benefit payment can dramatically improve claims processing across the health care system. Currently, there is no "one-stop shop" through which providers can easily sort out situations where people have coverage from multiple payers and verify the "primacy" of that coverage for billing purposes. The COB system will be a shared repository of patient coverage and primacy data which will match and compare records from different insurers and identify patients with overlapping coverage.

When third party coverage is discovered for fee-for-service participants in the public Minnesota Health Care Programs (MHCP), current DHS procedures require denying claims and remitting those claims back to providers for proper billing. The process of re-billing the correct coverage and then returning to bill MHCP for any remaining amount on the claim is time consuming and costly for providers. Using the COB system, providers would have access to coverage information submitted by large national insurers and could improve their chances of billing the appropriate payer and avoid repeated claims submissions.

DHS also conducts cost recovery when claims are paid before third party insurance coverage information is known. Participating in the COB project would improve access to coverage information, reducing the amount of "pay and chase" and claims reprocessing activities performed by DHS staff. Based on prior experience, DHS anticipates the additional third party coverage information will increase post payment recovery activity and produce budget savings through increased non-dedicated revenue to the general fund.

Proposal:

Under this proposal, DHS will contract with CAQH to participate in the COB project beginning in July, 2014 at a cost of 20 cents per MHCP enrollee per year, or about $225,000 annually. Under this contract, MHCP will submit weekly eligibility information and receive information in return with available insurance coverage information for everyone in the transmitted eligibility file. This coverage information, when received, will be verified and entered into the MMIS systems. The coverage information will be made available to managed care providers on a regular basis so they can conduct similar cost avoidance activities.

Participation in this project will improve the amount of third party coverage information to DHS, which will increase opportunities to recover paid fee for service Medical Assistance claims. Recent improvements in the collection of third party coverage information by DHS resulted in an average annual savings of nearly $10 million dollars over the last 3 years. The HIPAA compliant CAQH system contains third party coverage information for over 165 million people covered by health plans nationwide. Based on experience from previous improvements in third party coverage information, DHS assumes that additional recovery activities in the first year will increase collections by 10%. Access to this information will produce the most benefit in the initial year of participation, as DHS is permitted to recover funds from claims paid for the previous 36 months.

MN.IT Services Impacts from Proposal:

There will be work to the MMIS system to capture the insurance primacy information, for which there is no current storage identified. DHS will also need to transmit eligibility files to CAQH, and the cost of transmitting those files is included in this estimate.

Performance Measures:

This proposal will increase the amount of funds received from post payment provider recoveries.

Statutory Change: M.S. 256.01, Subd. 33

Statewide Outcome: This proposal primarily supports the following statewide outcome:

X	Health: All Minnesotans have optimal health
	Community: Strong and stable families and communities
	Safety: People in Minnesota are safe
	Education: Minnesotans have the education and skills needed to achieve their goals
	Government: Efficient and accountable government services

DHS Fiscal Detail for Budget Tracking

Net Impact by Fund ($000s)			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
General Fund				(94)	(202)	(209)
Health Care Access Fund						
Other Fund (Special Revenue)						
Total All Funds			**$0**	**($94)**	**($202)**	**($209)**
Budget Detail			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Fund	BACT	Description				
GF	13	Health Care Admin (P/T Contract)		113	225	225
GF	REV1	FFP @ 35%		(40)	(79)	(79)
GF	REV2	Non-Dedicated Revenue		(175)	(350)	(357)
GF	11	Operations: Systems (MMIS)		8	2	2
FTEs Requested						

Change Item Title: State Operated Services Salary Supplement

Fiscal Impact ($000s)	FY 2014	FY 2015	FY 2016	FY 2017
General Fund				
Expenditures	0	$ 12,050	$ 12,050	$ 12,050
Revenues	0	2,050	2,050	2,050
Net Fiscal Impact = (Expenditures – Revenues)	0	$ 10,000	$ 10,000	$ 10,000

Recommendation:

The Governor recommends an annual increase of $12,050,000 effective July 1, 2014 to fund negotiated cost-of-living adjustments for staff serving in State Operated Services programs. This is an ongoing increase to base operating appropriations from the General Fund with a net annual cost of $10,000,000. There is a county share charged for the cost of care in these programs.

Rationale/Background:

Department of Human Services (DHS), State Operated Services (SOS) provides an array of geographically dispersed residential and treatment programs and services for people with mental illness, developmental disabilities, chemical dependency, and traumatic brain injury who cannot be served by the private sector. In 2012, over 11,000 residential clients were served, with an additional 5,030 dental and 556 outpatient psychiatric clients. Currently, SOS Appropriated Services has 1,887 full time equivalents in staff.

SOS programs operate 24 hours a day, seven days a week, 365 days a year. More than 80% of the total operating expense is associated with staff salaries. Base funding has not been adjusted for cost of living increases since 2007. The department cannot continue to fund salary increases within the base funding without negatively affecting client services or closing some programs all together.

Proposal:

This proposal will fund the FY2015 cost to DHS/SOS from the negotiated cost of living adjustments that were approved for the current biennium and that must be provided to staff. The proposal covers SOS staff paid from direct appropriations only and does not fund cost of living adjustments for SOS direct care staff paid from enterprise funds.

Funding from this proposal will ensure appropriate staffing levels are in place in SOS programs as not to jeopardize client care or staff safety. If this proposed funding is not approved, SOS would need to reduce over 145 FTEs due to lack of funding. This would result in an inability to provide the level of care needed to support client needs and to comply with licensing, safety, and accreditation requirements.

MN.IT Services Impacts from Proposal:

There are no MN.IT impacts associated with implementation of this proposal.

Performance Measures:

Approval of the proposal will result in SOS being able to continue to safely service the current level of individuals and comply with licensing and accreditation requirements. This will be measured, quarterly, by the number of client episodes of care, treated and managed by SOS appropriated programs.

Statutory Change: Not Applicable

Statewide Outcome: This proposal primarily supports the following statewide outcome:

X	Health: All Minnesotans have optimal health
	Community: Strong and stable families and communities
	Safety: People in Minnesota are safe
	Education: Minnesotans have the education and skills needed to achieve their goals
	Government: Efficient and accountable government services

DHS Fiscal Detail for Budget Tracking

Net Impact by Fund ($000s)			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
General Fund				$ 10,000	$ 10,000	$ 10,000
Health Care Access Fund						
Other Fund (specify)						
Total All Funds			**$ -**	**$ 10,000**	**$ 10,000**	**$ 10,000**
Budget Detail			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Fund	BACT	Description				
1000	61	SOS Mental Health Svcs		7,230	7,230	7,230
1000	63	MN Security Hospital		4,820	4,820	4,820
1000	REV2	SOS Cost Recovery		(2,050)	(2,050)	(2,050)
FTEs Requested						

Change Item Title: Minnesota Sex Offender Program Salary Supplement

Fiscal Impact ($000s)	FY 2014	FY 2015	FY 2016	FY 2017
General Fund				
Expenditures	$ 0	$ 1,177	$ 1,177	$ 1,177
Revenues	0	(177)	(177)	(177)
Net Fiscal Impact = (Expenditures – Revenues)	$ 0	$ 1,000	$ 1,000	$ 1,000

Recommendation:

The Governor recommends an annual increase of $1,177,000 in effective July 1, 2014 to fund negotiated cost-of-living adjustments for staff serving in the Minnesota Sex Offender Program. This is an ongoing increase to base operating appropriations from the General Fund with a net annual cost of $1,000,000. There is a county share charged for the cost of care in this program.

Rationale/Background:

The Minnesota Sex Offender Program (MSOP), within the Department of Human Services (DHS), provides treatment for civilly committed individuals who are determined to be either a sexual psychopathic personality or sexually dangerous person or both. MSOP provides this treatment at the St. Peter and Moose Lake facilities. There are presently 509 clients located at Moose Lake and 189 located at St. Peter. MSOP currently has over 800 full time equivalents in staff.

MSOP operates 24 hours a day, 7 days a week, 365 days a year. More than 80% of the program's total operating expense is associated with staff salaries. The department is managing the MSOP salary cost pressure in the current 2014 fiscal year, but additional funding is needed to cover the added salary costs in FY2015. Base funding has not been adjusted for cost of living increases since 2007. The department cannot continue to fund salary increases within the base funding without negatively affecting client services or closing some programs all together.

Proposal:

This proposal will fund the FY2015 cost to DHS/MSOP from the negotiated cost of living adjustments that were approved for the current biennium and that must be provided to staff. The proposal covers all MSOP staff paid from direct appropriations.

This funding will ensure appropriate staffing levels are in place as needed to provide client care and ensure staff safety. The MSOP would have to reduce its complement of security or clinic staff by roughly 15 FTE if this increase is not granted.

MN.IT Services Impacts from Proposal:

There are no MN.IT impacts associated with implementation of this proposal.

Performance Measures:

MSOP treatment is individualized - based upon the clinical needs, risk potential, and responsiveness to treatment, for each client. Consistent with the research and standard clinical practices, MSOP provides integrated treatment including sex-offender-specific treatment, vocational and work opportunities, education, therapeutic recreation, and mental health services. To assess utilization of treatment services, over 80% of the population will be involved in sex offender treatment.

It is necessary to fund this salary supplement to ensure the program can maintain appropriate staffing levels so the current level of sex offender treatment and other clinical services are not interrupted or decreased.

Statutory Change: Not applicable

Statewide Outcome: This proposal primarily supports the following statewide outcome:

	Health: All Minnesotans have optimal health
	Community: Strong and stable families and communities

X	Safety: People in Minnesota are safe
	Education: Minnesotans have the education and skills needed to achieve their goals
	Government: Efficient and accountable government services

DHS Fiscal Detail for Budget Tracking

Net Impact by Fund ($000s)			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
General Fund			$ -	$ 1,000	$ 1,000	$ 1,000
Health Care Access Fund						
Other Fund (specify)						
Total All Funds			**$ -**	**$ 1,000**	**$ 1,000**	**$ 1,000**
Budget Detail			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Fund	BACT	Description				
GF	71	MSOP Salary Supplement	-	1,177	1,177	1,177
GF	REV2	Cost Recovery (county share)	-	(177)	(177)	(177)
FTEs Requested						

Change Item Title: Minnesota Sex Offender Program Expert Review Costs

Fiscal Impact ($000s)	FY 2014	FY 2015	FY 2016	FY 2017
General Fund				
Expenditures	$ 3,000	$ 0	$ 0	$ 0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	$ 3,000	$ 0	$ 0	$ 0

Recommendation:

The Governor recommends a one-time General Fund appropriation of $3 million for fiscal year 2014 to enable the commissioner to comply with the February 20, 2014, order of the United States District Court in the class action Karsjens, et al. vs. Jesson, et al. This order directs court-appointed experts to evaluate the Minnesota Sex Offender Program (MSOP) and to evaluate and assess each of its clients. The order requires the Department of Human Services to pay all costs relating to the court order.

Rationale/Background:

The Department of Human Services Minnesota Sex Offender Program (MSOP) provides treatment for civilly committed individuals who are determined to be either a sexual psychopathic personality or sexually dangerous person or both. MSOP provides this treatment at facilities located in St. Peter and Moose Lake. There are presently 509 clients located at Moose Lake and 189 located at St. Peter. MSOP currently has over 800 full time equivalents in staff.

The Karsjens court order requires that the experts it appointed pursue an aggressive review of MSOP – both the treatment program and the conditions of confinement. The court also ordered that every MSOP client be evaluated, focusing on each client's current level of dangerousness and suitability for discharge or placement in a less restrictive setting. In the order the Court "… reserves the right to amend, alter, or supplement its expert orders as [it decides is] necessary."

MSOP operates 24 hours a day, 7 days a week, 365 days a year. More than 80% of the program's total operating expense is associated with staff salaries. The department is currently managing a significant salary cost pressure in FY2014, but additional funding is needed to cover the added salary costs in FY2015. Based on the program's operating budget needs, the salary cost pressure and future budget projections, MSOP cannot absorb the $3 million that DHS has estimated is needed to comply with the recent court order.

Proposal:

This proposal funds the one-time costs associated with conducting and completing the Minnesota Sex Offender Program evaluation and client evaluations and other related directives that are required in the February 20, 2014 court order. This funding will ensure the department is able to comply with the court order.

The proposal includes funding for:

- The court monitor to conduct work over the next 18 months
- Expert evaluations for 720 clients at MSOP (based upon the court determined experts' estimate of hours and rate of pay)
- Overall research on other states as required in the order
- Client risk assessments for a subset of clients as determined by the experts

The department intends to move quickly to respond to and support the work of the court-ordered experts. However, because of uncertainty about how long the court-ordered activities will continue, this proposal makes the one-time appropriation available until June 30, 2017.

The activities that are necessary to comply with the court order are not considered to be part of the cost of care, thus there is no county share in funding this activity.

MN.IT Services Impacts from Proposal:

There are no MN.IT impacts associated with implementation of this proposal.

Performance Measures:

This proposal will result in the court and policymakers obtaining additional information about the Minnesota Sex Offender Program and its clients that will be useful in determining the future of the program.

Statutory Change: Rider.

Statewide Outcome: This proposal primarily supports the following statewide outcome:

	Health: All Minnesotans have optimal health
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	Government: Efficient and accountable government services

DHS Fiscal Detail for Budget Tracking

Net Impact by Fund ($000s)			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
General Fund			$ 3,000	$ -	$ -	$ -
Health Care Access Fund						
Other Fund (specify)						
Total All Funds			**$ 3,000**	**$ -**	**$ -**	**$ -**
Budget Detail			**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Fund	BACT	Description				
GF	71	MSOP	3,000	-	-	-
FTEs Requested						