HF3323 - 0 - "Modify State Operated Services"

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Commitee: **Health and Human Services Finance**
Date Completed: **04/12/2018**
Agency: Human Services Dept

State Fiscal Impact	Yes	No
Expenditures	X	
Fee/Departmental Earnings	X	
Tax Revenue		X
Information Technology	X	

Local Fiscal Impact	X	

This table shows direct impact to state government only. Local government impact, if any, is discussed in the narrative.
Reductions shown in the parentheses.

State Cost (Savings)			**Biennium**		**Biennium**
Dollars in Thousands	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**
General Fund	-	-	18,758	18,628	18,628
Total	**-**	**-**	**18,758**	**18,628**	**18,628**
Biennial Total			**18,758**		**37,256**

Full Time Equivalent Positions (FTE)			**Biennium**		**Biennium**
	FY2017	**FY2018**	**FY2019**	**FY2020**	**FY2021**
General Fund	-	-	1.5	1.5	1.5
Total	**-**	**-**	**1.5**	**1.5**	**1.5**

Executive Budget Officer's Comment

I have reviewed this fiscal note for reasonableness of content and consistency with MMB's Fiscal Note policies.

EBO Signature:Ahna Minge Date: 4/12/2018 11:23:49 AM
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State Cost (Savings) Calculation Details
This table shows direct impact to state government only. Local government impact, if any, is discussed in the narrative.
Reductions are shown in parentheses.
*Transfers In/Out and Absorbed Costs are only displayed when reported.

State Cost (Savings) = 1-2			Biennium		Biennium	
Dollars in Thousands	FY2017	FY2018	FY2019	FY2020	FY2021
General Fund	-	-	18,758	18,628	18,628
Total	**-**	**-**	**18,758**	**18,628**	**18,628**
Biennial Total			**18,758**		**37,256**
1 - Expenditures, Absorbed Costs*, Transfers Out*					
General Fund	-	-	302	172	172
Total	**-**	**-**	**302**	**172**	**172**
Biennial Total			**302**		**344**
2 - Revenues, Transfers In*					
General Fund	-	-	(18,456)	(18,456)	(18,456)
Total	**-**	**-**	**(18,456)**	**(18,456)**	**(18,456)**
Biennial Total			**(18,456)**		**(36,912)**

Bill Description

This bill modifies the county liability for cost of care at the Anoka-Metro Regional Treatment Center (AMRTC) and the Community Behavioral Health Hospitals (CBHHs) for individuals who are clinically appropriate for discharge from the hospital but remain in the facility for competency restoration services.

The bill also requires the Department of Human Services (DHS) to provide the counties 10 days advanced notice of a client's discharge and if the client is not discharged on that date due to any delay caused by DHS, the county shall not be charged for the cost of care.

In addition, the bill requires DHS to share with counties a comprehensive and continuously updated list of providers and facilities that counties can access in order to find timely and appropriate placements for clients.

Finally, the bill amends MS 256.045, Subd.3 to allow counties to appeal county cost of care under MS 246.54.

Assumptions

Cost of care in a state-operated facility is the responsibility of the patient/client unless other payers, including health plans and/or counties, have been identified. For health plan coverage to be available during a stay an individual must be clinically appropriate for a stay in a hospital (meet hospital level of care criteria).

Cost of care for individuals served at AMRTC and the CBHHs is charged on a per diem rate. The rate is calculated based on the methodology used for Minnesota Medicaid State Plan for Regional Treatment Centers. The calculation divides total cost for the facility by total expected patient days. As all beds are licensed hospital beds, regulation and certification require us to provide hospital level services to patients while they are being served in these facilities.

Minnesota Statute §246.54 Liability of County; Reimbursement, assigns a county's portion of cost of care for state-operated facilities when no other payer is available. County liability is established by facility and is a percentage of the per diem rate. The balance of the per diem not assigned to the county is billed to the individual being served unless the service is covered by a third party payer. Third party payers are always billed first, before a county, to ensure only non-covered costs have a county portion applied.

Sections 1 and 2
The language as written says a county would be 100% liable for the cost of care at AMRTC and the CBHHs provided (i) the discharge plan does not recommend a referral to a competency restoration programand the facilities meets the notification requirements In applying this change, the balance of the cost of care would become the responsibility of the

client. If the client or client's responsible relative cannot pay, the balance would continue to be held for future action including a claim against the client's estate. Historically, clients do not have the resources to pay their cost of care and therefore any charges billed to the client would be considered lost revenue to the general fund.

Section 3

This section of the bill requires facilities to provide a 10 day advance notice and preliminary discharge plan prior to a client's discharge. The language also specified that if on or after the discharge date, the client is not discharged due to any delay caused by the facility, the county must not be charged for the cost of care. Due to the placement of this language, this notice would apply to all inpatient services provided under Minnesota Statues §246.54.

Counties are legally responsible for identifying and placing a patient at the next level of care after a psychiatric inpatient hospital stay. It has been Direct Care and Treatment (DCT) practice that facility staff engage counties upon a client's admission to begin the discharge planning process. Most counties work with DCT staff and are kept up to date with a client's treatment status. Due to the fluidity of a client's psychiatric treatment, it is almost impossible to predict that a client is stable and may be discharged within a 10 day time frame; therefore, DCT would not be able to comply with this section for AMRTC and CBHHs. Consequently, all do not meet criteria days would not be charged to the counties, but rather the client and be considered a loss of revenue to the general fund.

Federal regulation provided by the Centers for Medicare and Medicaid Services (CMS) dictate that a client must be notified the day that they no longer require hospital level of care not 10 days prior. DCT will continue to comply with CMS rules/regulation. If we do not, we could jeopardize compliance with regulations which could result in termination of certification and licensure and potentially cause an inability to bill for services provided.

This section would also apply to state-operated Forensic Services programs. Special Review Board (SRB) and other commitment notification requirements are already in place and are being completed for most Forensic Services programs within the 10 day notification requirement of this section. However, it will be difficult to comply with the 10 day notification for the Forensic Competency Restoration Program and the Community Competency Restoration Program.

Section 4

Section 4 requires DHS to develop a comprehensive and continually updated list of providers and facilities for counties to access to find appropriate discharge placements. This is a very broad statement as written and would be very costly to implement and maintain. After a discussion with a stakeholder involved in drafting the language, it was determined that their intent was that this language be limited to just state-operated services; therefore, this analysis is limited to just state-operated services.

DCT currently maintains a bed management system. To convert this to a list accessibly to counties would require MN.IT involvement for planning, development and implementation**.** In addition, a 1.0 Management Analyst 4 position would be required to update/maintain the system and interact with the counties on a daily basis.

Section 5

This section allows counties to dispute county cost of care under Minnesota Statutes §246.54. By adding this language this would increase the number of appeal hearings conducted by the Department of Human Services. Currently there are about 2,000 individuals receiving services annually under Section §246.54. Approximately 10% are likely to appeal. This equates to about 200 hearings and would require an additional 0.50 FTE Human Services Judge.

The bill language does not identify an effective date. It is assumed these changes would be effective 7/1/2018.

Expenditure and/or Revenue Formula

Expenditures:

Salary Expense (Sections 4 and 5):

	Annual Salary Expense	Fringe At 30%	Total Salary Expense
1.0 Management Analyst 4 (MAPE 15L, Mid-Range)	$67,547	$20,264	$87,811
0.5 Human Services Judge (MAPE 16L, Mid-Range)	$34,990	$10,497	$45,487

Total	$102,537	$30,761	$133,298

Assumes positions are not hired until Oct. 1, 2018; therefore, only 10 months of operating expense is identified for fiscal year 2019.

One-time overhead expense (workplace furnishings & installation, computer, phones, etc.) is approximately $14,500. On-going monthly overhead expense (occupancy, training, supplies, etc.) is approximately $1,200 per month.

Section 4:

MN.IT Expense

	FY2019	FY2020	FY2021
Planning, Development & Implementation	$161,259	$0	$0
Estimated On-going Maintenance Costs	$0	$32,252	$32,252
Total (100% State Share no FFP)	$161,259	$32,252	$32,252

Revenue:

An average daily census (ADC) is calculated based on the total number days clients at AMRTC and the CBHHs do not meet hospital level of care criteria (DNMC). The days are broken out between Rule 20 (needing competency restoration services) and Non-Rule 20 (all other). The data is from calendar year 2017.

	Non Rule 20	Rule 20	Total DMNC Days	Total ADC
AMRTC	6,001	4,765	10,766	29
CBHH	2,497	0	2,497	7
Total	8,498	4,765	13,263	36
ADC	23	13	36	

Section 1, 2 & 3:

Since it is assumed that DCT will not be able to meet the 10-day notification under Section 3, the table below shows the cost of shifting the charges for cost of care from the counties to the client for all clients that no longer require hospital level of care. Clients and/or their responsibly relative typically do not have the resources to pay their cost of care and therefore this revenue is considered a loss to the general fund.

	Average Daily Census	Per Diem Rate	Percent Billed	Estimated Revenue ($000's)
AMRTC	29	$1,390	100%	$14,713
CBHHs	7	$1,465	100%	$3,743
Total				**$18,456**

There would be an additional loss of revenue due to non-compliance with the 10 day notice for the Forensic Competency Restoration Program (CRP) and the Community Competency Restoration Program (CCPR); however, we do not have enough data to estimate this potential loss.

Fiscal Tracking Summary ($000's)						
Fund	**BACT**	**Description**	**FY2018**	**FY2019**	**FY2020**	**FY2021**
GF	65	Personnel Cost DCT		73	88	88
GF	65	Overhead Expense		27	14	14
		Total Operating Expense BACT 65		100	102	102

GF	10	Personnel Cost Central Office		37	45	45
GF	10	Overhead Expense		27	14	14
GF	Rev1	Admin FFP @ 35%		(23)	(21)	(21)
		Total Operating Expense BACT10		41	38	38
GF	11	State Share of Systems Cost		$161	$32	$32
GF	Rev1	Lost Cost of Care Collections		18,456	18,456	18,456
		Total Net Fiscal Impact		18,758	18,628	18,628
GF	65	**Full Time Equivalents DCT**		1.0	1.0	1.0
GF	10	**Full Time Equivalents - Operations**		0.5	0.5	0.5

Long-Term Fiscal Considerations

There would be a large increase in the state's open receivables account for cost of care.

Local Fiscal Impact

Reduction in the county liability of cost of care at AMRTC and CBHHs.

References/Sources

Department of Human Services Bulletin #17-77-01 Direct Care and Treatment Cost of Care Rates as of July 1, 2017

Agency Contact:

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