| Fiscal Impact ($000s) | FY 2008 | FY 2009 | FY 2010 | FY 2011 |
|---|---|---|---|---|
| General Fund | | | | |
| Expenditures | $1,853 | $6,755 | $7,304 | $7,807 |
| Revenues | 2,288 | 6,320 | 7,304 | 7,807 |
| Health Care Access Fund | | | | |
| Expenditures | 13,088 | 30,370 | 34,788 | 34,816 |
| Revenues | 69 | (1,103) | (2,120) | (2,623) |
| Net Fiscal Impact | $12,584 | $31,908 | $36,908 | $37,439 |

## Recommendation

The Governor recommends adoption of a number of measures totaling $44.492 million over the coming biennium to improve the accessibility, quality, and accountability of publicly funded mental health services. The Governor recommends using health care access fund resources to fund this proposal.

## Background

Mental illness, especially untreated or inadequately treated mental illness, has an enormous impact on our society. Data developed by the massive Global Burden of Disease study conducted by the World Health Organization, the World Bank, and Harvard University were used to evaluate the societal impact of disease through factors such as premature mortality, lost productivity, and treatment costs. The study reveals that mental illness, including suicide, accounts for over 15% of the burden of disease in established market economies, such as the United States. This is more than the disease burden caused by all cancers and second only to heart disease. Mental illness also has an enormous impact on our public programs, playing a significant role in the public cost of providing physical health care, substance abuse, special education, corrections, child welfare, vocational, and income maintenance services.

The Minnesota Mental Health Action Group (MMHAG) began in 2003 as a public-private partnership to take concrete action to improve the state's mental health system. In its report, "Road Map for Mental Health System Reform in Minnesota," MMHAG identified the following desired outcomes:

- public/private partnerships to assure that all aspects of the mental health system are working to serve consumers and families;
- a new fiscal framework for public and private mental health funding that creates rational incentives for the right care to be delivered in the right setting at the right time;
- quality of care for consumers and families, as measured by standardized assessment of performance and outcomes;
- innovative workforce solutions to assure an adequate supply of appropriately trained, qualified mental health professionals;
- earlier identification and intervention for mental health issues so that consumers and families are willing to seek and able to access help when needed; and
- coordination of care and services so the mental health system is easy for consumers and families to navigate and they receive the right combination of services to achieve the desired health and social outcomes.

In 2005, the Department of Human Services (DHS) was charged with building on the work of MMHAG to develop a proposal for reforming the financing of the public mental health system. To that end, this proposal was designed to honor MMHAG principles and objectives and was introduced to the 2006 legislature as the Governor's Mental Health Initiative. While the 2006 legislature adopted some of the proposed measures, much was deferred to discussion of the FY 2008-09 operating budget. This proposal reintroduces the Governor's Mental Health Initiative.

The proposed improvements in the public mental health system build on DHS's existing health care programs, the Prepaid Medical Assistance Program (PMAP), General Assistance Medical Care (GAMC), and MinnesotaCare. The funding reforms reflect the need to integrate mental health treatment within the mainstream health care delivery system, ensure coordination with social services, and improve the underlying financial incentives for

timely, effective care. Implementation of the funding system reforms would be phased in over the next few years. Some changes would be implemented statewide, while others would be phased in on a regional basis before statewide implementation. Finally, the proposal recognizes the struggling mental health service infrastructure serves all Minnesotans, not just those in public health care programs, and proposes investments in this infrastructure to benefit all those who use it.

Proposed investments and system reforms include:

⇒ ***Adopt a consistent mental health benefit set across all DHS health care programs.***
While the mental health coverage under the current Medical Assistance (MA) fee-for-service program approximates the model benefit set developed and endorsed by MMHAG, the coverage for adults in two of the state's health care programs, GAMC and MinnesotaCare, does not yet include all the necessary benefits. Further, some mental health benefits are included under the state's contracts with pre-paid health plans while others are only available on a fee-for-service basis.

This means that enrollees in these programs get some of their mental health care paid for and managed by their health plan and some paid for with property tax levy funds or state and federal categorical grants, mostly managed by counties. This split in funding and benefits provides opportunities for cost shifting, avoidance of accountability, breaks in communication, and fragmented service delivery. Worse, enrollees can find themselves in situations where they must actually get sicker in order to access services they need. With a uniform benefit set across all publicly funded health care programs, consumers would face less disruption in care and encounter improved coordination across providers. The move should also shift incentives toward earlier identification and intervention and away from more expensive care and the cost shifting it encourages. The mental health benefit changes would be phased in over CY 2008-09. In CY 2008, GAMC/MinnesotaCare benefits would be expanded to include all outpatient mental health services covered in MA except for mental health targeted case management (MH-TCM). In CY 2009, MH-TCM would be added as a covered benefit and all non-inpatient mental health benefits would be available in both the pre-paid and fee-for-service sides of the state's health care programs.

For most of these services, the adoption of the model benefit set represents the state's assumption of services that were completely a county responsibility or, in the case of MH-TCM and children's residential mental health treatment, the state's assumption of the local share of treatment costs. Accordingly, the state proposes to repeal the existing MH-TCM grants and to use these funds to cover the cost of current county-funded services and clients transferred to state-funded programs. Any grant funds not used for this purpose will remain with counties to provide services to the uninsured or under-insured. The proposed legislation includes a provision ensuring that the difference becomes a part of each county's on-going base funding for Adult and Children's Mental Health Grants.

The total net costs of proposed benefit changes are estimated at $1.064 million in FY 2008, $4.789 million in FY 2009, $4.781 million in FY 2010, and $5.061 million in FY 2011.

⇒ ***Implement an intensive mental health outpatient treatment benefit within the Minnesota Health Care Programs.***
The current benefit structure for outpatient mental health services is poorly suited for reimbursement of dialectical behavioral therapy, a time-intensive approach for people with borderline personality disorder. The result is that individuals with these disorders are served inadequately and sometimes inappropriately through existing coverage. The proposed response is to develop a new code and reimbursement rate effective 7-1-2008 that fits the intensity of the service provided. DHS will establish a certification process to identify qualified providers who may be reimbursed for this intensive outpatient service. One time-limited staff position is requested to oversee implementation of the benefit, establish the certification process, and supply provider training.

Appropriations totaling $528,000 in FY 2009 and $1.101 million in FY 2010 and FY 2011 are requested to implement the intensive mental health outpatient treatment benefit.

⇒ ***Increase the portion of public health care clients whose mental health services are provided through integrated health care networks and demonstrate methods to improve the coordination between mental health care, physical health care, and social services.***

An increasing body of research shows significant interaction between a person's physical and mental well being. Health care networks have done much to promote the prevention, early identification, and effective treatment of many physical diseases.

A significant number of persons eligible for Medical Assistance (MA), however, are not in pre-paid health care networks, but instead use fee-for-service MA for all their health care. Generally, the MA enrollees using fee-for-service fall in two distinct groups: persons eligible for MA because they meet disability criteria and persons who opt out of PMAP because, while not considered disabled, they meet serious emotional disturbance/serious and persistent mental illness (SED/SPMI) criteria. Persons with disabling mental health conditions often need supportive social services in addition to physical and mental health care. These social services are provided by counties and various non-profit agencies. Ensuring effective coordination of all three service areas presents some special challenges. A variety of strategies might be applied to meet these challenges and the best strategies may vary based on the strengths and weaknesses of the organizations partnering to coordinate those services.

New law passed in 2006 (M.S. 256B.69, Subd 28) provides authority for persons with disabilities to access basic health care through a new managed care option designed specifically for people with disabilities. The mental health initiative builds on that new option and proposes the following features to fully integrate mental and physical health care while maintaining coordination with social services:

♦ Use a request for proposals (RFP) process to create local projects to demonstrate and phase-in methods of integrating mental health care, health care, and social services at the local level. Created through the RFP process, one of the enrollment options within the project region would feature an enhanced, coordinated delivery system or "preferred integrated care network" based on partnerships between the counties and a health care network within the region. Additional local partners may include schools, children's collaboratives, and non-profit mental health service agencies. An important feature of the projects would be to take advantage of a new federal Medicare option called a "Special Needs Plan," which allows integrated management of Medicare funds, including funds from the Part D pharmacy benefit, for individuals dually eligible for Medicaid and Medicare. This would greatly increase opportunities for making effective, coordinated use of the otherwise unwieldy Medicare payment system.

  In CY 2007, DHS would work with consumer advocates and other stakeholders to develop a RFP outlining the performance criteria for the regional projects. In CY 2008, local projects would be selected from the applicants based on the soundness of their preparation and plans for achieving those criteria. Implementation of the regional projects will then begin with CY 2009. The first phase of local projects would be limited to creating preferred integrated care networks available to no more than 40% of the state's eligible population.

  Within each project's geographic area, the enrollment of persons with SED and SPMI will be phased in as the "preferred integrated networks" (PINs) develop the capacity to meet their needs. Medical Assistance eligibles currently on fee-for service with an SED or SPMI will be preferentially enrolled in the preferred integrated network with the following exceptions:

  - Persons who meet eligibility criteria for home and community-based waiver services for the developmentally disabled will remain in fee-for-service Medical Assistance;
  - Persons eligible for exclusion from PMAP under Minnesota Statutes section 256B.69, Subd. 4. for reasons independent of their mental illness (such as children on adoption assistance status) may remain in fee-for service medical assistance;
  - Persons who do not wish to enroll in a preferred integrated network may elect to enroll in another available pre-paid health plan in their area;

- Persons eligible for Medical Assistance because of their disability status or who are SPMI may elect prior to enrollment to remain in fee-for service and, if enrolled in a network, may request to return to fee-for-service at any time, and;
- In areas that have a preferred integrated network, non-disabled children with SED will be required to choose either a PIN or another available pre-paid plan.

Because of funding arrangements established last year in M.S. 256B.69, Subd. 28, the net state cost of the proposed integration and enrollment changes outlined above is estimated to be budget neutral until FY 2011, when a net state cost of $208,000 is realized. Implementation of this section requires administrative support to manage the new enrollment procedures, perform actuarial work, increase state managed care ombudsman staffing, and conduct an external quality review of the project. The net agency administrative costs are estimated at $103,000 in FY 2008 and $424,000 in FY 2009, and $361,000 in both FY 2010 and FY 2011.

⇒ **Address workforce shortages and infrastructure stability problems by increasing Minnesota Health Care Program rates for certain mental health services and providers.**

The 2006 legislature provided a 23.7% rate increase for psychiatric services and for certain services provided by providers classified as mental health centers or essential community providers. However, there are a number of key providers and services that were not covered by the 2006 rate increase. These include smaller Children's Therapeutic Services and Supports (CTSS) providers when they provide the services which were included in the 2006 rate increase. Also the rate increase would be extended to children's mental health behavioral aid and AMHRS medication education services. This proposal would match the 2006 rate increase for these additional providers and services effective 1-1-08.

Appropriations totaling $380,000 in FY 2008, $1.97 million in FY 2009, and $3.010 million in FY 2010 and $3.013 million in FY 2011 are requested to extend the 23.7% rate increase to these specific providers and services that were not addressed in the 2006 session.

⇒ ***Develop accountability and system management investments.***

The MMHAG process identified some information gaps that have hampered the ability for the state, counties, and other payers to manage the mental health system and make it accountable.

♦ ***Develop a system for collecting and evaluating mental health treatment outcomes.***

The proposed evaluation system would provide client outcomes data to complement current client demographic and service utilization data. It would allow the state to assess the quality, clinical appropriateness, and effectiveness of services. Expanding data collection capacity would give the state powerful performance monitoring tools for use in managing its contracts with managed care organizations under the proposed mental health financing reforms. It would also inform technical assistance on best practices to counties and providers and supply consumers with information necessary to make informed choices among treatment options.

Since the proposed system would collect personal health care data, protections would be included to comply with the requirements of the Minnesota Data Practices Act and federal Health Insurance Portability and Accountability Act (HIPAA).

The 2006 legislature approved the use of Health Care Access Funds to design the information system, develop systems analysis, and pilot initial phases of a web-based statewide outcomes evaluation system for mental health services. The current proposal is to fund the ongoing operational costs beginning in FY 2009.

Administrative funding with a net cost of $61,000 per year beginning in FY 2009 is requested to maintain operation of the outcomes reporting system.

- ***Monitor and track the availability of mental health services.***
  In order to make efficient use of mental health services, DHS proposed to develop and maintain a statewide web-based system to monitor and track availability of public and private mental health services within the state. The system will start tracking the availability of inpatient and community residential services and then expand to track availability of other services, such as assertive community treatment teams. The tracking system will help crisis service providers and emergency room staff in quickly locating appropriate service options for those in need of immediate intervention and treatment.

  The 2006 legislature appropriated administrative funding totaling $150,000 in FY 2007 and $52,000 in FY 2008 to establish the tracking system. This proposal seeks $60,000 each year beginning in FY 2009 to maintain the tracking system once it is operational.

⇒ **Improve county financial incentives for ensuring community-based service access for the uninsured.**

Counties have a significant local investment in funding mental health services. As the state assumes responsibility for the comprehensive benefit set across its health care programs, it is important to preserve this investment and to provide incentives for its appropriate use to serve those without public or private health care coverage. Historically, the state has heavily subsidized care in the state's regional treatment centers. This subsidy does not provide incentives to keep the focus on providing appropriate community-based care and preventing costly hospitalizations. DHS proposes that the county share for uninsured stays at Anoka Metro Regional Treatment Center would be reduced from the current 20% to zero for the first 30 days, continue at the current 20% for the $31^{st}$ thru the $60^{th}$ day, and increase to 50% for any days over 60. The investments in the mental health service infrastructure elsewhere in this proposal provide counties with the tools to avoid unnecessary admissions to regional treatment centers and to facilitate timely discharges. These changes would be effective 1-1-08.

Increasing the county share of state operated treatment center costs generates an estimated $2.288 million in General Fund revenue in FY 2008 and $4.576 million per year from FY 2009 through FY 2011.

⇒ ***Ensure statewide access to services by targeting grant funds to support the service delivery infrastructure.***
The changes outlined earlier in this proposal implement vast improvements in mental health service delivery for persons who are eligible for the Minnesota Health Care Programs (MHCP). However, services provided through these programs can't address issues relating to persons not eligible for MHCP or beyond the control of individual payers. State-level public investment is necessary to ensure statewide availability of many mental health services. Support of the service infrastructure benefits all Minnesotans, both the uninsured and those with public or private health coverage. This proposal would provide state grant funding to address the following mental health service access issues:

- *A statewide mental health crisis intervention and stabilization infrastructure*.
  Infrastructure investment grants would be employed to develop and support crisis response services as a first line safety net for both adults and children. Current levels of uncompensated care for these services (over 30%) make it impossible to maintain a viable system of crisis services for either public or private sector clients on just the revenue generated through public and private insurers. Crisis service providers cannot refuse services to individuals who have no coverage.

  Crisis intervention and stabilization services, where implemented, have been shown effective in stabilizing persons in a psychiatric crisis and reducing costs associated with emergency room and inpatient hospital care. Much of the current crowding and backlog in emergency rooms is due to the lack of more appropriate mental health crisis services.

  Crisis services are currently covered by MA for both adults and children and would become covered under GAMC and MinnesotaCare with proposed benefit changes. DHS will work with providers to

maximize revenues from both public and private coverage. Funding would be used to develop the infrastructure for all populations and cover non-billable time and on-going costs for the remaining uninsured and underinsured individuals.

The 2006 legislature appropriated $1 million in FY 2007 and FY 2008 to help ensure the availability of mental health crisis services. This proposal seeks to increase that amount by $3 million in FY 2008 and to establish base funding amounts of $7 million in FY 2009 and $9 million in FY 2010 and FY 2011.

- *Shore up children's school- and community-based mental health services infrastructure.*
  Infrastructure investment grants would help address urgent problems facing children's mental health service capacity in our state. A primary funding source for children's mental health collaboratives (known as the Local Collaborative Time Study or LCTS) has experienced a marked decline in revenue due to changes in federal regulations. This funding previously supported much of the state's school-based mental health service infrastructure. These co-located mental health services are critical to the educational success of many children with severe emotional problems. The funding also supports a variety of outreach activities, service coordination, and early childhood programs designed to prevent or address developing mental health problems that could jeopardize a child's success at school. The grants would primarily pay for services to uninsured and under-insured children or services for which there is no available coverage.

  Appropriations of $6.825 million for FY 2008 and $13.65 million per year beginning in FY 2009 are requested to support the school-based mental health treatment and early childhood development infrastructure through children's mental health and family service collaboratives.

- *Develop and support evidence-based practices and best practices.*
  The infrastructure investment grants would support development and utilization of evidence-based and best practices in the mental health system. Funds would be earmarked for local service start-up costs and ongoing costs for uninsured and underinsured individuals. Examples include
  ⇒ co-located service models in primary care, pediatrics, schools, and public health settings;
  ⇒ Medical Home models for physician-directed care coordination between physical and mental health services;
  ⇒ Integrated Dual Diagnosis (mental illness/chemical dependency) Treatment across the service delivery system;
  ⇒ Assertive Community Treatment (ACT) teams in the seven-county metro area;
  ⇒ application of treatment research in daily clinical decision making for children and adolescents and use of technology to aid in effective treatment planning

  Appropriations of $1.5 million for FY 2008 and $3 million for FY 2009, and $4 million for FY 2010 and SFY 2011 are requested to fund grants to develop and support local implementation of evidence-based and best practices beginning in CY 2008.

- *Develop and support treatment resources for groups with specialized treatment needs.*
  Finally, grants would develop and support specialty programs, such as those for culturally specific populations, or challenging "niche" treatment populations, such as those persons with eating disorders or treatment resistant psychoses. Funds would be earmarked for local service start-up costs and ongoing costs for uninsured and underinsured individuals.

  Appropriations of $500,000 for FY 2008 and $2 million in FY 2009 and $2.5 million in FY 2010 and SFY 2011 are requested to fund grants to develop and support local implementation specialty treatment resources.

- *Expand access to a range of housing options.*

This proposal is intended to complement a proposal from the Housing Finance Agency to increase the state's "Bridges" program which currently provides about $1.6 million annually in rent subsidies to persons with mental illness who are waiting for their applications for Section 8 housing to be processed and accepted. There are a number of adults with serious mental illness whose housing needs are more complex than can be addressed through rent subsidy. These needs may include additional supervision and support to assure safety and stability. This proposal includes funding for startup and ongoing costs associated with the specialized housing options that are sometimes needed by adults with serious mental illness.

Appropriations of $1.5 million for FY 2008 and $3 million per year in FY 2009-11 are requested to fund grants to expand the availability of a range of housing options for persons with mental illness.

## Relationship to Base Budget

This proposal significantly increases state funded mental health services.

## Key Measures

Improved patient functioning and reduced symptoms of mental illness or emotional disturbance.

**Statutory Change**: M.S. 245; 256B; 256D; 256L

**Fiscal Detail Budget Tracking**

| Fund | BACT or Non-ded. REV | Description | FY 2008 | FY 2009 | FY 2010 | FY 2011 |
|---|---|---|---|---|---|---|
| | | **See detail attached below** | | | | |
| FTEs Requested | | | | | | |
| 190 | 50 | Health Care Admin – Integrated care for MH disabled | | 3 | 3 | 3 |
| 190 | 85 | Cont Care Admin – Integrated care to MH disabled | | 1 | 1 | 1 |
| 190 | 85 | Cont Care Admin – Implement intensive outpt benefit | | 1 | 1 | 1 |
| 190 | 85 | Cont Care Admin – Maintain Outcomes System | | 1 | 1 | 1 |

## Governor's Mental Health Initiative - 2007 Budget Request

*Proposal Component*

*Adopt a consistent mental health benefit set across all DHS health care programs by making GAMC and MnCare benefit set consistent with MA effective 1/1/08. Also integration of TCM and Rule 5 coverage in PMAP and MnCare. Finance general fund part of the new coverage and the county share of TCM and Rule 5 via repeal of MH-TCM Transfer Grants.*

| Fund | BACT | Description | FY 2008 | FY 2009 | FY2010 | FY2011 |
|---|---|---|---|---|---|---|
| Gen | 26 | Balance of CMH-TCM transfer grants | $1,873 | $4,757 | $2,842 | $2,842 |
| Gen | 41 | MH-TCM and Rule 5 to PMAP | $0 | $2,448 | $5,138 | $5,391 |
| Gen | 42 | MA Basic HC E&D - repeal TCM Grants | ($3,740) | ($11,528) | ($11,528) | ($11,528) |
| Gen | 42 | Add MH-TCM to Program IM | $0 | $167 | $321 | $257 |
| Gen | 43 | Add MH-TCM & Adult MH Rehab | $910 | $3,166 | $4,454 | $4,557 |
| Gen | 74 | Balance of AMH-TCM Transfer Grants | $934 | $2,344 | ($941) | ($941) |
| | | Subtotal General Fund | ($23) | $1,354 | $286 | $578 |

| Fund | Code | Item | | | | |
|---|---|---|---|---|---|---|
| HCAF | 40 | Add MH-TCM and Rule 5 for children | $0 | $158 | $332 | $349 |
| HCAF | 40 | Add MH-TCM for adults | $0 | $638 | $1,544 | $1,586 |
| HCAF | 40 | Add MH rehab services for adults | $1,014 | $2,470 | $2,412 | $2,382 |
| HCAF | 40 | Add Neuropsych, Day Tx and Part Hosp | $73 | $169 | $167 | $166 |
| | | Subtotal HCAF | $1,087 | $3,435 | $4,455 | $4,483 |
| | | Total All Funds | $1,064 | $4,789 | $4,741 | $5,061 |

*Intensive Outpatient Benefit*

| Fund | Code | Item | | | | |
|---|---|---|---|---|---|---|
| Gen | 41 | MA Basic Health Care F&C | $0 | $24 | $55 | $55 |
| Gen | 42 | MA Basic Health Care E&D | $0 | $399 | $926 | $926 |
| Gen | 43 | General Assistance Medical Care Grants | $0 | $21 | $48 | $48 |
| | | Subtotal General Fund | $0 | $444 | $1,029 | $1,029 |
| HCAF | 40 | Minnesota Care Grants | $0 | $9 | $20 | $20 |
| HCAF | 51 | MMIS systems costs | $0 | $18 | $0 | $0 |
| HCAF | 85 | Project staff & admin costs | $0 | $95 | $86 | $86 |
| HCAF | REV1 | Administrative FFP | $0 | ($38) | ($34) | ($34) |
| | | Subtotal Health Care Access Fund | $0 | $84 | $72 | $72 |
| | | Total All Funds | $0 | $528 | $1,101 | $1,101 |

*Increase the portion of public health care clients whose mental health services are funded through capitated, managed care purchasing strategies and explore ways to improve the coordination between mental health care, physical health care and social services. Moving people from FFS to Managed Care.*

| Fund | Code | Item | FY 2008 | FY 2009 | FY2010 | FY2011 |
|---|---|---|---|---|---|---|
| Gen | 26 | Transfer Children's MH Grants | $0 | ($416) | ($1,556) | ($1,556) |
| Gen | 41 | MA Basic Health Care F&C | $0 | $166 | $622 | $648 |
| Gen | 42 | MA Basic Health Care E&D | $0 | $947 | $3,582 | $3,764 |
| Gen | 74 | Transfer Adult MH Grants | $0 | ($697) | ($2,648) | ($2,648) |
| | | Subtotal transition of clients to MCOs | $0 | $0 | $0 | $208 |
| HCAF | 50 | Health Care purchasing staff and actuarial | $50 | $332 | $308 | $308 |
| HCAF | 50 | External Quality Review | | $500 | $500 | $500 |
| HCAF | 51 | MMIS systems costs | $0 | $18 | $0 | $0 |
| HCAF | 85 | Project oversight staff & admin costs | $122 | $136 | $86 | $86 |
| HCAF | REV1 | Administrative FFP | ($69) | ($562) | ($533) | ($533) |
| | | Subtotal HCAF Admin Costs | $103 | $424 | $361 | $361 |
| | | Total All Funds | $103 | $424 | $361 | $569 |

*Address workforce shortages / increase rates for providers who didn't get increases in previous two sessions by adding CTSS providers, mental health behavioral aid services and ARMHS medical education services to the providers and services included in the rate increase passed in 2006.*

| Fund | Code | Item | | | | |
|---|---|---|---|---|---|---|
| Gen | 41 | MA Basic Health Care F&C | $34 | $177 | $271 | $271 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Gen | 42 | MA Basic Health Care E&D | $338 | $1,762 | $2,690 | $2,693 |
| Gen | 43 | General Assistance Medical Care Grants | $4 | $18 | $28 | $28 |
| HCAF | 40 | Minnesota Care Grants | $4 | $15 | $21 | $21 |
| | | Total All Funds | $380 | $1,972 | $3,010 | $3,013 |

*Create a system for measuring mental health service outcomes*

| | | | | | | |
|---|---|---|---|---|---|---|
| HCAF | 85 | Continuing Care Administration | $0 | $102 | $102 | $102 |
| HCAF | REV1 | Administrative FFP | $0 | ($41) | ($41) | ($41) |
| | | Total All Funds | $0 | $61 | $61 | $61 |

*Create a system for tracking acute care / mental health service availability*

| | | | | | | |
|---|---|---|---|---|---|---|
| HCAF | 74 | Adult Mental Health Grants | $0 | $60 | $60 | $60 |
| | | Total All Funds | $0 | $60 | $60 | $60 |

*Improve incentives for ensuring community-based service access for the uninsured. County share for uninsured commitments to state operated regional treatment centers.*

| | | | | | | |
|---|---|---|---|---|---|---|
| Gen | REV2 | SOS Collections | ($2,288) | ($4,576) | ($4,576) | ($4,576) |

*Ensure statewide access and support the service delivery infrastructure by targeting grant funds.*

| *- Mobile Mental health crisis services infrastructure* | | FY 2008 | FY 2009 | FY2010 | FY2011 | |
|---|---|---|---|---|---|---|
| HCAF | 26 | Children's Services Grants | $1,500 | $3,500 | $4,500 | $4,500 |
| HCAF | 74 | Adult Mental Health Grants | $1,500 | $3,500 | $4,500 | $4,500 |
| | | Total All Funds | $3,000 | $7,000 | $9,000 | $9,000 |

*- Children's mental health school-based infrastructure - treatment services grants & early child development*

| | | | | | | |
|---|---|---|---|---|---|---|
| HCAF | 26 | Children's Services Grants | $4,350 | $8,700 | $8,700 | $8,700 |
| HCAF | 26 | Children's Services Grants | $2,475 | $4,950 | $4,950 | $4,950 |
| | | Total All Funds | $6,825 | $13,650 | $13,650 | $13,650 |

*- Support evidence-based and best practices*

| | | | | | | |
|---|---|---|---|---|---|---|
| HCAF | 26 | Children's Services Grants | $750 | $1,500 | $2,000 | $2,000 |
| HCAF | 74 | Adult Mental Health Grants | $750 | $1,500 | $2,000 | $2,000 |
| | | Total All Funds | $1,500 | $3,000 | $4,000 | $4,000 |

*- Culturally Specific and specialty treatment*

| | | | | | | |
|---|---|---|---|---|---|---|
| HCAF | 26 | Children's Services Grants | $250 | $1,000 | $1,250 | $1,250 |
| HCAF | 74 | Adult Mental Health Grants | $250 | $1,000 | $1,250 | $1,250 |
| | | Total All Funds | $500 | $2,000 | $2,500 | $2,500 |

*- Expanded Housing Options*

| | | | | | | |
|---|---|---|---|---|---|---|
| Gen | 74 | Adult Mental Health Grants | $1,500 | $3,000 | $3,000 | $3,000 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | Total All Funds | $1,500 | $3,000 | $3,000 | $3,000 |
| *Increase Transfer from Health Care Access Fund to General Fund* | | | | | | |
| Gen | REV2 | Transfer from HCAF | $0 | ($1,744) | ($2,728) | ($3,231) |
| HCAF | REV | Transfer to GF | $0 | $1,744 | $2,728 | $3,231 |
| SUMMARY | | | | | | |
| Gen | 26 | Children's Services Grants | $1,873 | $4,341 | $1,286 | $1,286 |
| Gen | 41 | MA Basic Health Care F&C | $34 | $2,815 | $6,086 | $6,365 |
| Gen | 42 | MA Basic Health Care E&D | ($3,402) | ($8,253) | ($4,009) | ($3,888) |
| Gen | 43 | General Assistance Medical Care Grants | $914 | $3,205 | $4,530 | $4,633 |
| Gen | 74 | Adult Mental Health Grants | $2,434 | $4,647 | ($589) | ($589) |
| Gen | REV2 | SOS Collections | ($2,288) | ($4,576) | ($4,576) | ($4,576) |
| Gen | REV2 | Transfer from HCAF | $0 | ($1,744) | ($2,728) | ($3,231) |
| | | Subtotal General Fund | ($435) | $435 | $0 | $0 |
| HCAF | 26 | Children's Services Grants | $9,325 | $19,650 | $21,400 | $21,400 |
| HCAF | 74 | Adult Mental Health Grants | $2,500 | $6,060 | $7,810 | $7,810 |
| HCAF | 40 | Minnesota Care Grants | $1,091 | $3,459 | $4,496 | $4,524 |
| HCAF | 50 | Health Care Administration | $50 | $832 | $808 | $808 |
| HCAF | 51 | Health Care Operations | $0 | $36 | $0 | $0 |
| HCAF | 85 | Continuing Care Administration | $122 | $333 | $274 | $274 |
| HCAF | REV1 | Administrative FFP | ($69) | ($641) | ($608) | ($608) |
| HCAF | REV2 | Transfer to General Fund | $0 | $1,744 | $2,728 | $3,231 |
| | | Subtotal Health Care Access Fund | $13,019 | $31,473 | $36,908 | $37,439 |
| | | Total All Funds | $12,584 | $31,908 | $36,908 | $37,439 |