..... moves to amend H.F. No. 2294 as follows:

Delete everything after the enacting clause and insert:

"**ARTICLE 1**

HEALTH CARE

Section 1. Minnesota Statutes 2010, section 256B.0625, subdivision 28a, is amended to read:

Subd. 28a. **Licensed physician assistant services.** (a) Medical assistance covers services performed by a licensed physician assistant if the service is otherwise covered under this chapter as a physician service and if the service is within the scope of practice of a licensed physician assistant as defined in section 147A.09.

(b) Licensed physician assistants, who are supervised by a physician certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry, may bill for medication management and evaluation and management services provided to medical assistance enrollees in inpatient hospital settings, consistent with their authorized scope of practice, as defined in section 147A.09, with the exception of performing psychotherapy or providing clinical supervision.

Sec. 2. Minnesota Statutes 2011 Supplement, section 256B.0625, subdivision 38, is amended to read:

Subd. 38. **Payments for mental health services.** Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals shall be 80 percent of the rate paid to doctoral-prepared professionals. Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals employed by community mental health centers shall be 100 percent of the rate paid to doctoral-prepared professionals. Payments for mental health services covered

under the medical assistance program that are provided by physician assistants shall be 65 percent of the rate paid to doctoral-prepared professionals.

Sec. 3. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 60. **Community paramedic services.** (a) Medical assistance covers services provided by community paramedics who are certified under section 144E.28, subdivision 9, when the services are provided in accordance with this subdivision to an eligible recipient as defined in paragraph (b).

(b) For purposes of this subdivision, an eligible recipient is defined as an individual who has received hospital emergency department services three or more times in a period of four consecutive months in the past 12 months or an individual who has been identified by the individual's primary health care provider for whom community paramedic services identified in paragraph (c) would likely prevent admission to or would allow discharge from a nursing facility; or would likely prevent readmission to a hospital or nursing facility.

c) Payment for services provided by a community paramedic under this subdivision must be a part of a care plan ordered by a primary health care provider in consultation with the medical director of an ambulance service and must be billed by an eligible provider enrolled in medical assistance that employs or contracts with the community paramedic. The care plan must ensure that the services provided by a community paramedic are coordinated with other community health providers and local public health agencies and that community paramedic services do not duplicate services already provided to the patient, including home health and waiver services. Community paramedic services shall include health assessment, chronic disease monitoring and education, medication compliance, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow-up care, and minor medical procedures approved by the ambulance medical director.

(d) Services provided by a community paramedic to an eligible recipient who is also receiving care coordination services must be in consultation with the providers of the recipient's care coordination services.

(e) The commissioner shall seek the necessary federal approval to implement this subdivision.

EFFECTIVE DATE. This section is effective July 1, 2012, or upon federal approval, whichever is later.

Sec. 4. Minnesota Statutes 2011 Supplement, section 256B.0631, is amended to read:

256B.0631 MEDICAL ASSISTANCE CO-PAYMENTS.

Subdivision 1. ~~**Cost-sharing**~~ **Co-payments.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following ~~cost-sharing~~ co-payments for all recipients, effective for services provided on or after September 1, 2011:

(1) $3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

~~(2) $3 for eyeglasses;~~

~~(3)~~ (2) $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval;

~~(4)~~ (3) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and

~~(5) effective January 1, 2012, a family deductible equal to the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54; and~~

~~(6)~~ (4) for individuals identified by the commissioner with income at or below 100 percent of the federal poverty guidelines, total monthly ~~cost-sharing~~ co-payments must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on cost-sharing.

(b) Recipients of medical assistance are responsible for all co-payments ~~and deductibles~~ in this subdivision.

Subd. 2. **Exceptions.** Co-payments ~~and deductibles~~ shall be subject to the following exceptions:

(1) children under the age of 21;

(2) pregnant women for services that relate to the pregnancy or any other medical condition that may complicate the pregnancy;

(3) recipients expected to reside for at least 30 days in a hospital, nursing home, or intermediate care facility for the developmentally disabled;

(4) recipients receiving hospice care;

(5) 100 percent federally funded services provided by an Indian health service;

(6) emergency services;

(7) family planning services;

(8) services that are paid by Medicare, resulting in the medical assistance program paying for the coinsurance and deductible; and

(9) co-payments that exceed one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room.

Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall be reduced by the amount of the co-payment ~~or deductible~~, except that reimbursements shall not be reduced:

(1) once a recipient has reached the $12 per month maximum for prescription drug co-payments; or

(2) for a recipient identified by the commissioner under 100 percent of the federal poverty guidelines who has met their monthly five percent ~~cost-sharing~~ co-payment limit.

(b) The provider collects the co-payment ~~or deductible~~ from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment ~~or deductible~~.

(c) Medical assistance reimbursement to fee-for-service providers and payments to managed care plans shall not be increased as a result of the removal of co-payments ~~or deductibles~~ effective on or after January 1, 2009.

Sec. 5. Minnesota Statutes 2010, section 256B.0751, is amended by adding a subdivision to read:

Subd. 9. **Pediatric care coordination.** The commissioner shall implement a pediatric care coordination service for children with high-cost medical or high-cost psychiatric conditions who are at risk of recurrent hospitalization or emergency room use for acute, chronic, or psychiatric illness, who receive medical assistance services. Care coordination services must be targeted to children not already receiving care coordination through another service, and may include but are not limited to the provision of health care home services to children admitted to hospitals that do not currently provide care coordination. Care coordination services must be provided by care coordinators who are directly linked to provider teams in the care delivery setting, but who may be part of a community care team shared by multiple primary care providers or practices. For purposes of this subdivision, the commissioner shall, to the extent possible, use the existing health care home certification and payment structure established under this section and section 256B.0753.

Sec. 6. Minnesota Statutes 2010, section 256B.441, is amended by adding a subdivision to read:

Subd. 63. **Special needs nursing facility rate adjustment.** The commissioner may increase the medical assistance payment rate for a nursing facility that is participating in a health care delivery system demonstration project under sections 256B.0755 or 256B.0756, or another care coordination project, if the nursing facility has agreed to accept patients enrolled in the project in order to reduce hospital or emergency room admissions or readmissions, shorten the length of inpatient hospital stays, or prevent a medical emergency that would require more costly treatment. The higher rate must reflect the higher costs of participating in the care coordination demonstration project and the higher costs of serving patients with more complex medical, dental, mental health, and socioeconomic conditions.

Sec. 7. Minnesota Statutes 2011 Supplement, section 256B.69, subdivision 5a, is amended to read:

Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and section 256L.12 shall be entered into or renewed on a calendar year basis beginning January 1, 1996. Managed care contracts which were in effect on June 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995 through December 31, 1995 at the same terms that were in effect on June 30, 1995. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B and 256L is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B and 256L established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) Effective for services rendered on or after January 1, 2003, the commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must be based on evidence-based research showing they can be achieved through reasonable interventions, and developed with input from independent clinical experts and stakeholders, including managed care plans and providers. The managed care plan

must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

(d) Effective for services rendered on or after January 1, 2009, through December 31, 2009, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(e) Effective for services provided on or after January 1, 2010, the commissioner shall require that managed care plans use the assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies consistent with medical assistance fee-for-service or the Department of Human Services contract requirements consistent with medical assistance fee-for-service or the Department of Human Services contract requirements for all personal care assistance services under section 256B.0659.

(f) Effective for services rendered on or after January 1, 2010, through December 31, 2010, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(g) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency room utilization rate for state health care program enrollees by a measurable rate of five percent from the plan's utilization rate for state health care program enrollees for the previous calendar year. Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health

plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For calendar year 2012, the reduction shall be based on the health plan's utilization in calendar year 2009, and to earn the return of the withhold for that year, the plan must achieve a qualifying reduction of no less than ten percent compared to calendar year 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding Medicare enrollees, compared to the previous calendar year, until the final performance target is reached. Measurement of performance shall take into account the difference in health risk in a plan's membership in the baseline year compared to the measurement year.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year ~~2011~~2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(h) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding Medicare enrollees, compared to the previous calendar year until the final performance target is reached. Measurement of performance shall take into account the difference in health risk in a plan's membership in the baseline year compared to the measurement year.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing

plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospital admission rate compared to the hospital admission rates in calendar year 2011, as determined by the commissioner. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (i). Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(i) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding Medicare enrollees, of no less than five percent compared to the previous calendar year until the final performance target is reached.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in the subsequent hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding Medicare enrollees, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

(j) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than

July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(k) Effective for services rendered on or after January 1, 2012, through December 31, 2012, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(l) Effective for services rendered on or after January 1, 2013, through December 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(m) Effective for services rendered on or after January 1, 2014, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(n) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

(o) Contracts between the commissioner and a prepaid health plan are exempt from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and 7.

(p) The return of the withhold under paragraphs (d), (f), and (j) to (m) is not subject to the requirements of paragraph (c).

Sec. 8. Minnesota Statutes 2011 Supplement, section 256B.69, subdivision 5c, is amended to read:

Subd. 5c. **Medical education and research fund.** (a) The commissioner of human services shall transfer each year to the medical education and research fund established under section 62J.692, an amount specified in this subdivision. The commissioner shall calculate the following:

(1) an amount equal to the reduction in the prepaid medical assistance payments as specified in this clause. Until January 1, 2002, the county medical assistance capitation base rate prior to plan specific adjustments and after the regional rate adjustments under subdivision 5b is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and no reduction for nonmetropolitan Minnesota counties; and after January 1, 2002, the county medical assistance capitation base rate prior to plan specific adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing facility and elderly waiver payments and demonstration project payments operating under subdivision 23 are excluded from this reduction. The amount calculated under this clause shall not be adjusted for periods already paid due to subsequent changes to the capitation payments;

(2) beginning July 1, 2003, $4,314,000 from the capitation rates paid under this section;

(3) beginning July 1, 2002, an additional $12,700,000 from the capitation rates paid under this section; and

(4) beginning July 1, 2003, an additional $4,700,000 from the capitation rates paid under this section.

(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research fund. The amount specified under paragraph (a), clauses (1) to (4), shall not exceed the total amount transferred for fiscal year 2009. Any excess shall first reduce the amounts specified under paragraph (a), clauses (2) to (4). Any excess following this reduction shall proportionally reduce the amount specified under paragraph (a), clause (1).

(c) Beginning September 1, 2011, of the amount in paragraph (a), the commissioner shall transfer $21,714,000 each fiscal year to the medical education and research fund.

(d) Beginning September 1, 2011, of the amount in paragraph (a), following the transfer under paragraph (c), the commissioner shall transfer to the medical education research fund $23,936,000 in fiscal ~~years~~ year 2012 ~~and~~, $24,936,000 in fiscal year 2013, and $36,744,000 in fiscal year 2014 and thereafter.

Sec. 9. Minnesota Statutes 2010, section 256B.69, subdivision 9, is amended to read:

Subd. 9. **Reporting.** (a) Each demonstration provider shall submit information as required by the commissioner, including data required for assessing client satisfaction, quality of care, cost, and utilization of services for purposes of project evaluation. The commissioner shall also develop methods of data reporting and collection in order to

provide aggregate enrollee information on encounters and outcomes to determine access and quality assurance. Required information shall be specified before the commissioner contracts with a demonstration provider.

(b) Aggregate nonpersonally identifiable health plan encounter data, aggregate spending data for major categories of service as reported to the commissioners of health and commerce under section 62D.08, subdivision 3, clause (a), and criteria for service authorization and service use are public data that the commissioner shall make available and use in public reports. The commissioner shall require each health plan and county-based purchasing plan to provide:

(1) encounter data for each service provided, using standard codes and unit of service definitions set by the commissioner, in a form that the commissioner can report by age, eligibility groups, and health plan; and

(2) criteria, written policies, and procedures required to be disclosed under section 62M.10, subdivision 7, and Code of Federal Regulations, title 42, part 438.210(b)(1), used for each type of service for which authorization is required.

(c) Each demonstration provider shall report to the commissioner on the extent to which providers employed by or under contract with the demonstration provider use patient-centered decision-making tools or procedures designed to engage patients early in the decision-making process and the steps taken by the demonstration provider to encourage their use.

Sec. 10. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision to read:

Subd. 32. **Initiatives to reduce incidence of low birth weight.** The commissioner shall require managed care and county-based purchasing plans, as a condition of contract, to implement strategies to reduce the incidence of low birth weight in geographic areas identified by the commissioner as having a higher than average incidence of low birth weight. The strategies must coordinate health care with social services and the local public health system. Each plan shall develop and report to the commissioner outcome measures related to reducing the incidence of low birth weight. The commissioner shall consider the outcomes reported when considering plan participation in the competitive bidding program established under subdivision 33.

Sec. 11. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision to read:

Subd. 33. **Competitive bidding.** (a) For managed care contracts effective on or after January 1, 2014, the commissioner shall establish a competitive price bidding program for nonelderly, nondisabled adults and children in medical assistance and MinnesotaCare in the seven-county metropolitan area. The program must allow a minimum of two managed care plans to serve the metropolitan area.

(b) In designing the competitive bid program, the commissioner shall consider, and incorporate where appropriate, the procedures and criteria used in the competitive bidding pilot authorized under Laws 2011, First Special Session chapter 9, article 6, section 96.

(c) The commissioner shall require managed care plans to submit data on enrollee health outcomes and shall consider this information, along with competitive bid and other information, in determining whether to contract with a managed care plan under this subdivision. The data submitted must include health outcome measures on reducing the incidence of low birth weight established by the managed care plan under subdivision 32.

Sec. 12. Minnesota Statutes 2011 Supplement, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Except as provided in paragraphs (b) and (c), the MinnesotaCare benefit plan shall include the following cost-sharing requirements for all enrollees:

(1) ten percent of the paid charges for inpatient hospital services for adult enrollees, subject to an annual inpatient out-of-pocket maximum of $1,000 per individual;

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

(4) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist; and

(5) $6 for nonemergency visits to a hospital-based emergency room for services provided through December 31, 2010, and $3.50 effective January 1, 2011~~; and~~.

~~(6) a family deductible equal to the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54.~~

(b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21.

(c) Paragraph (a) does not apply to pregnant women and children under the age of 21.

(d) Paragraph (a), clause (4), does not apply to mental health services.

(e) Adult enrollees with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant shall be financially responsible for the coinsurance amount, if applicable, and amounts which exceed the $10,000 inpatient hospital benefit limit.

(f) When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, any charges submitted towards the $10,000 annual inpatient benefit limit, and any out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

(g) MinnesotaCare reimbursements to fee-for-service providers and payments to managed care plans or county-based purchasing plans shall not be increased as a result of the reduction of the co-payments in paragraph (a), clause (5), effective January 1, 2011.

Sec. 13. Minnesota Statutes 2011 Supplement, section 256L.12, subdivision 9, is amended to read:

Subd. 9. **Rate setting; performance withholds.** (a) Rates will be prospective, per capita, where possible. The commissioner may allow health plans to arrange for inpatient hospital services on a risk or nonrisk basis. The commissioner shall consult with an independent actuary to determine appropriate rates.

(b) For services rendered on or after January 1, 2004, the commissioner shall withhold five percent of managed care plan payments and county-based purchasing plan payments under this section pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must be based on evidence-based research showing they can be achieved through reasonable interventions, and developed with input from independent clinical experts and stakeholders, including managed care plans and providers. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, such as characteristics of

the plan's enrollee population. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if performance targets in the contract are achieved.

(c) For services rendered on or after January 1, 2011, the commissioner shall withhold an additional three percent of managed care plan or county-based purchasing plan payments under this section. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year. The return of the withhold under this paragraph is not subject to the requirements of paragraph (b).

(d) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's emergency room utilization rate for state health care program enrollees by a measurable rate of five percent from the plan's utilization rate for the previous calendar year. Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For calendar year 2012, the reduction shall be based on the health plan's utilization in calendar year 2009, and to earn the return of the withhold for that year, the plan must achieve a qualifying reduction of no less than ten percent compared to calendar year 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's utilization rate for medical assistance and MinnesotaCare enrollees, excluding Medicare enrollees, compared to the previous calendar year, until the final performance target is reached. Measurement of performance shall take into account the difference in health risk in a plan's membership in the baseline year compared to the measurement year.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year ~~2011~~ 2009. Hospitals shall cooperate with the health plans in meeting this performance target and

shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding Medicare enrollees, compared to the previous calendar year, until the final performance target is reached. Measurement of performance shall take into account the difference in health risk in a plan's membership in the baseline year compared to the measurement year.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospitals admission rate compared to the hospital admission rate for calendar year 2011 as determined by the commissioner. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (f).

(f) Effective for services provided on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization rate for a subsequent hospitalization within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospital admissions rate for medical assistance and MinnesotaCare enrollees, excluding Medicare enrollees, of no less than five percent compared to the previous calendar year until the final performance target is reached.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan

demonstrates to the satisfaction of the commissioner that a reduction in the subsequent hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

(g) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

Sec. 14. **DATA ON CLAIMS AND UTILIZATION.**

The commissioner of human services shall develop and provide to the legislature by December 15, 2012, a methodology and any draft legislation necessary to allow for the release, upon request, of summary data as defined in Minnesota Statutes, section 13.02, subdivision 19, on claims and utilization for medical assistance and MinnesotaCare enrollees at no charge to the University of Minnesota Medical School, the Mayo Medical School, Northwestern Health Sciences University, the Institute for Clinical Systems Improvement, and other research institutions in Minnesota to conduct analyses of health care outcomes and treatment effectiveness, provided:

(1) a data-sharing agreement is in place that ensures compliance with the Minnesota Government Data Practices Act;

(2) the commissioner of human services determines that the work would produce analyses useful in the administration of the medical assistance or MinnesotaCare programs; and

(3) the research institutions do not release private or nonpublic data or data for which dissemination is prohibited by law.

Sec. 15. **MANAGING MEDICAL ASSISTANCE FEE-FOR-SERVICE CARE DELIVERY.**

The commissioner of human services shall issue, by July 1, 2012, a request for proposals to develop and administer a care delivery management system for medical assistance enrollees served under fee-for-service. The care delivery management system

must improve health care quality and reduce unnecessary health care costs through the: (1) use of predictive modeling tools and comprehensive patient encounter data to identify missed preventive care and other gaps in health care delivery and to identify chronically ill and high-cost enrollees for targeted interventions and care management; (2) use of claims data to evaluate health care providers for overall quality and cost-effectiveness and make this information available to enrollees; and (3) establishment of a program integrity initiative to reduce fraudulent or improper billing. The commissioner shall award a contract under the request for proposals to a Minnesota-based organization by October 1, 2012. The contract must require the organization to implement the care delivery management system by July 1, 2013.

Sec. 16. **DELIVERING HEALTH CARE THROUGH STATE PROGRAMS.**

Subdivision 1. **Plan submittal.** The commissioner of human services, in consultation with the commissioners of health and commerce, shall develop and submit to the legislature, by December 15, 2012, a plan to restructure and reform medical assistance, MinnesotaCare, and other state health care programs. The plan must be designed to maintain and improve health care access, quality, cost-effectiveness, and affordability, in the event that the federal government makes significant changes in Medicaid service delivery, eligibility, and financing.

Subd. 2. **Plan criteria.** The plan submitted by the commissioner must:

(1) provide for continuity of care and minimize any loss of health care access or coverage;

(2) emphasize personal responsibility and involvement in making choices about health care;

(3) provide patients and health care providers with financial incentives to use and deliver health care services efficiently and achieve better health outcomes;

(4) incorporate innovative and effective health care delivery approaches, including but not limited to approaches based on defined contributions to enrollees and a system of coordinated care delivery models; and

(5) build upon, and be consistent with, recent state health care reform initiatives related to improving health care quality and increasing transparency in health care.

Sec. 17. **PHYSICIAN ASSISTANTS AND OUTPATIENT MENTAL HEALTH.**

The commissioner of human services shall convene a group of interested stakeholders to assist the commissioner in developing recommendations on how to

improve access to, and the quality of, outpatient mental health services for medical assistance enrollees through the use of physician assistants. The commissioner shall report these recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and financing, by January 15, 2013.

ARTICLE 2

DEPARTMENT OF HEALTH

Section 1. Minnesota Statutes 2010, section 62D.02, subdivision 3, is amended to read:

Subd. 3. **Commissioner of ~~health~~ commerce or commissioner.** "Commissioner of ~~health~~ commerce" or "commissioner" means the state commissioner of ~~health~~ commerce or a designee.

EFFECTIVE DATE. This section is effective August 1, 2012.

Sec. 2. Minnesota Statutes 2010, section 62D.05, subdivision 6, is amended to read:

Subd. 6. **Supplemental benefits.** (a) A health maintenance organization may, as a supplemental benefit, provide coverage to its enrollees for health care services and supplies received from providers who are not employed by, under contract with, or otherwise affiliated with the health maintenance organization. Supplemental benefits may be provided if the following conditions are met:

(1) a health maintenance organization desiring to offer supplemental benefits must at all times comply with the requirements of sections 62D.041 and 62D.042;

(2) a health maintenance organization offering supplemental benefits must maintain an additional surplus in the first year supplemental benefits are offered equal to the lesser of $500,000 or 33 percent of the supplemental benefit expenses. At the end of the second year supplemental benefits are offered, the health maintenance organization must maintain an additional surplus equal to the lesser of $1,000,000 or 33 percent of the supplemental benefit expenses. At the end of the third year benefits are offered and every year after that, the health maintenance organization must maintain an additional surplus equal to the greater of $1,000,000 or 33 percent of the supplemental benefit expenses. When in the judgment of the commissioner the health maintenance organization's surplus is inadequate, the commissioner may require the health maintenance organization to maintain additional surplus;

(3) claims relating to supplemental benefits must be processed in accordance with the requirements of section 72A.201; and

(4) in marketing supplemental benefits, the health maintenance organization shall fully disclose and describe to enrollees and potential enrollees the nature and extent of the

supplemental coverage, and any claims filing and other administrative responsibilities in regard to supplemental benefits.

(b) The commissioner may, pursuant to chapter 14, adopt, enforce, and administer rules relating to this subdivision, including: rules insuring that these benefits are supplementary and not substitutes for comprehensive health maintenance services by addressing percentage of out-of-plan coverage; rules relating to the establishment of necessary financial reserves; rules relating to marketing practices; and other rules necessary for the effective and efficient administration of this subdivision. ~~The commissioner, in adopting rules, shall give consideration to existing laws and rules administered and enforced by the Department of Commerce relating to health insurance plans.~~

EFFECTIVE DATE. This section is effective August 1, 2012.

Sec. 3. Minnesota Statutes 2010, section 62D.12, subdivision 1, is amended to read:

Subdivision 1. **False representations.** No health maintenance organization or representative thereof may cause or knowingly permit the use of advertising or solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. Each health maintenance organization shall be subject to sections 72A.17 to 72A.32, relating to the regulation of trade practices, except ~~(a)~~ to the extent that the nature of a health maintenance organization renders such sections clearly inappropriate ~~and (b) that enforcement shall be by the commissioner of health and not by the commissioner of commerce~~. Every health maintenance organization shall be subject to sections 8.31 and 325F.69.

EFFECTIVE DATE. This section is effective August 1, 2012.

Sec. 4. Minnesota Statutes 2010, section 144.292, subdivision 6, is amended to read:

Subd. 6. **Cost.** (a) When a patient requests a copy of the patient's record for purposes of reviewing current medical care, the provider must not charge a fee.

(b) When a provider or its representative makes copies of patient records upon a patient's request under this section, the provider or its representative may charge the patient or the patient's representative no more than 75 cents per page, plus $10 for time spent retrieving and copying the records, unless other law or a rule or contract provide for a lower maximum charge. This limitation does not apply to x-rays. The provider may charge a patient no more than the actual cost of reproducing x-rays, plus no more than $10 for the time spent retrieving and copying the x-rays.

(c) The respective maximum charges of 75 cents per page and $10 for time provided in this subdivision are in effect for calendar year 1992 and may be adjusted annually each calendar year as provided in this subdivision. The permissible maximum charges shall change each year by an amount that reflects the change, as compared to the previous year, in the Consumer Price Index for all Urban Consumers, Minneapolis-St. Paul (CPI-U), published by the Department of Labor.

(d) A provider or its representative may charge the $10 retrieval fee, but must not charge a per page fee to provide copies of records requested by a patient or the patient's authorized representative if the request for copies of records is for purposes of appealing a denial of Social Security disability income or Social Security disability benefits under title II or title XVI of the Social Security Act. For the purpose of further appeals, a patient may receive no more than two medical record updates without charge, but only for medical record information previously not provided. For purposes of this paragraph, a patient's authorized representative does not include units of state government engaged in the adjudication of Social Security disability claims.

Sec. 5. Minnesota Statutes 2010, section 144.293, subdivision 2, is amended to read:

Subd. 2. **Patient consent to release of records.** A provider, or a person who receives health records from a provider, may not release a patient's health records to a person without:

(1) a signed and dated consent from the patient or the patient's legally authorized representative authorizing the release;

(2) specific authorization in law; or

(3) in the case of a medical emergency, a representation from a provider that holds a signed and dated consent from the patient authorizing the release.

Sec. 6. **[144.586] PATIENT SAFETY SURVEY.**

Hospitals licensed under section 144.55 must submit necessary information to the Leapfrog Group patient safety survey on an annual basis in order to publicly report patient safety information and track the progress of each hospital to improve quality, safety, and efficiency of care delivery.

Sec. 7. **EVALUATION OF HEALTH AND HUMAN SERVICES REGULATORY RESPONSIBILITIES.**

Relating to the evaluations and legislative report completed pursuant to Laws 2011, First Special Session chapter 9, article 2, section 26, the following activities must be completed:

(1) the commissioners of health and human services must update, revise, and link the contents of their Web sites related to supervised living facilities, intermediate care facilities for the developmentally disabled, nursing facilities, board and lodging establishments, and human services licensed programs so that consumers and providers can access consistent clear information about the regulations affecting these facilities; and

(2) the commissioner of management and budget, in consultation with the commissioners of health and human services, must evaluate and recommend options for administering health and human services regulations. The evaluation and recommendations must be submitted in a report to the legislative committees with jurisdiction over health and human services no later than August 1, 2013, and shall at a minimum: (i) identify and evaluate the regulatory responsibilities of the departments of health and human services to determine whether to organize these regulatory responsibilities to improve how the state administers health and human services regulatory functions, or whether there are ways to improve these regulatory activities without reorganizing; and (ii) describe and evaluate the multiple roles of the Department of Human Services as a direct provider of care services, a regulator, and a payor for state program services.

Sec. 8. **STUDY OF FOR-PROFIT HEALTH MAINTENANCE ORGANIZATIONS.**

The commissioner of health shall contract with an entity with expertise in health economics and health care delivery and quality to study the efficiency, costs, service quality, and enrollee satisfaction of for-profit health maintenance organizations, relative to not-for-profit health maintenance organizations operating in Minnesota and other states. The study findings must address whether the state could: (1) reduce medical assistance and MinnesotaCare costs and costs of providing coverage to state employees; and (2) maintain or improve the quality of care provided to state health care program enrollees and state employees if for-profit health maintenance organizations were allowed to operate in the state. The commissioner shall require the entity under contract to report study findings to the commissioner and the legislature by January 15, 2013.

Sec. 9. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall, in conforming with section 1, change the terms "commissioner of health" or similar term to "commissioner of commerce" or similar term and "department of health" or similar term to "department of commerce" or similar term in each place it occurs in Minnesota Statutes, chapters 62D, 62E, 62J, 62L, 62M, 62Q, 62U, and 256B, and in each place it occurs in Minnesota Rules, chapter 4685, in reference to the regulatory oversight of health maintenance organizations. .

EFFECTIVE DATE. This section is effective August 1, 2012.

ARTICLE 3

CHILDREN AND FAMILY SERVICES

Section 1. Minnesota Statutes 2010, section 119B.13, subdivision 3a, is amended to read:

Subd. 3a. **Provider rate differential for accreditation.** A family child care provider or child care center shall be paid a ~~15~~ 16 percent differential above the maximum rate established in subdivision 1, up to the actual provider rate, if the provider or center holds a current early childhood development credential or is accredited. For a family child care provider, early childhood development credential and accreditation includes an individual who has earned a child development associate degree, a child development associate credential, a diploma in child development from a Minnesota state technical college, or a bachelor's or post baccalaureate degree in early childhood education from an accredited college or university, or who is accredited by the National Association for Family Child Care or the Competency Based Training and Assessment Program. For a child care center, accreditation includes accreditation ~~by~~ that meets the following criteria: the accrediting organization must demonstrate the use of standards that promote the physical, social, emotional, and cognitive development of children. The accreditation standards shall include, but are not limited to, positive interactions between adults and children, age-appropriate learning activities, a system of tracking children's learning, use of assessment to meet children's needs, specific qualifications for staff, a learning environment that supports developmentally appropriate experiences for children, health and safety requirements, and family engagement strategies. The commissioner of human services, in conjunction with the commissioners of education and health, will develop an application and approval process based on the criteria in this section and any additional criteria. The process developed by the commissioner of human services must address periodic reassessment of approved accreditations. The commissioner of human services must report the criteria developed, the application, approval, and reassessment processes, and any additional recommendations by February 15, 2013, to the chairs and ranking

minority members of the legislative committees having jurisdiction over early childhood issues. The following accreditations shall be recognized for the provider rate differential until an approval process is implemented: the National Association for the Education of Young Children, the Council on Accreditation, the National Early Childhood Program Accreditation, the National School-Age Care Association, or the National Head Start Association Program of Excellence. For Montessori programs, accreditation includes the American Montessori Society, Association of Montessori International-USA, or the National Center for Montessori Education.

Sec. 2. Minnesota Statutes 2011 Supplement, section 119B.13, subdivision 7, is amended to read:

Subd. 7. **Absent days.** (a) ~~Licensed~~ Child care providers ~~and license-exempt centers must~~ may not be reimbursed for more than ~~ten~~ 25 full-day absent days per child, excluding holidays, in a fiscal year, or for more than ten consecutive full day absent days, unless the child has a documented medical condition that causes more frequent absences. Absences due to a documented medical condition of a parent or sibling who lives in the same residence as the child receiving child care assistance do not count against the 25 day absent day limit in a fiscal year. Documentation of medical conditions must be on the forms and submitted according to the timelines established by the commissioner. A public health nurse or school nurse may verify the illness in lieu of a medical practitioner. If a provider sends a child home early due to a medical reason, including, but not limited to, fever or contagious illness, the child care center director or lead teacher may verify the illness in lieu of a medical practitioner. ~~Legal nonlicensed family child care providers must not be reimbursed for absent days.~~ If a child attends for part of the time authorized to be in care in a day, but is absent for part of the time authorized to be in care in that same day, the absent time must be reimbursed but the time must not count toward the ten consecutive or 25 cumulative absent day ~~limit~~ limits. Children in families where at least one parent is under the age of 21, does not have a high school or general equivalency diploma, and is a student in a school district or another similar program that provides or arranges for child care, as well as parenting, social services, career and employment supports, and academic support to achieve high school graduation, may be exempt from the absent day limits upon request of the program and approval by the county. If a child attends part of an authorized day, payment to the provider must be for the full amount of care authorized for that day. Child care providers must only be reimbursed for absent days if the provider has a written policy for child absences and charges all other families in care for similar absences.

(b) Child care providers must be reimbursed for up to ten federal or state holidays or designated holidays per year when the provider charges all families for these days and the holiday or designated holiday falls on a day when the child is authorized to be in attendance. Parents may substitute other cultural or religious holidays for the ten recognized state and federal holidays. Holidays do not count toward the ten consecutive or 25 cumulative absent day ~~limit~~ limits.

(c) A family or child care provider must not be assessed an overpayment for an absent day payment unless (1) there was an error in the amount of care authorized for the family, (2) all of the allowed full-day absent payments for the child have been paid, or (3) the family or provider did not timely report a change as required under law.

(d) The provider and family shall receive notification of the number of absent days used upon initial provider authorization for a family and ongoing notification of the number of absent days used as of the date of the notification.

(e) A county may pay for more absent days than the statewide absent day policy established under this subdivision if current market practice in the county justifies payment for those additional days. County policies for payment of absent days in excess of the statewide absent day policy and justification for these county policies must be included in the county's child care fund plan under section 119B.08, subdivision 3.

EFFECTIVE DATE. This section is effective January 1, 2013.

Sec. 3. Minnesota Statutes 2011 Supplement, section 256.987, subdivision 1, is amended to read:

Subdivision 1. **Electronic benefit transfer (EBT) card.** Cash benefits for the general assistance and Minnesota supplemental aid programs under chapter 256D and programs under chapter 256J must be issued on ~~a separate~~ an EBT card with the name of the head of household printed on the card. The card must include the following statement: "It is unlawful to use this card to purchase tobacco products or alcoholic beverages." This card must be issued within 30 calendar days of an eligibility determination. During the initial 30 calendar days of eligibility, a recipient may have cash benefits issued on an EBT card without a name printed on the card. This card may be the same card on which food support benefits are issued and does not need to meet the requirements of this section.

Sec. 4. Minnesota Statutes 2011 Supplement, section 256.987, subdivision 2, is amended to read:

Subd. 2. **Prohibited purchases.** An individual with an EBT ~~debit cardholders in~~ card issued for one of the programs listed under subdivision 1 ~~are~~ is prohibited from using

the EBT debit card to purchase tobacco products and alcoholic beverages, as defined in section 340A.101, subdivision 2. ~~It is unlawful for an EBT cardholder to purchase or attempt to purchase tobacco products or alcoholic beverages with the cardholder's EBT card.~~ Any ~~unlawful use~~ prohibited purchases made under this subdivision shall constitute ~~fraud~~ unlawful use and result in disqualification of the cardholder from the program ~~under section 256.98, subdivision 8~~ as provided in subdivision 4.

Sec. 5. Minnesota Statutes 2011 Supplement, section 256.987, is amended by adding a subdivision to read:

Subd. 3. **EBT use restricted to certain states.** EBT debit cardholders in programs listed under subdivision 1 are prohibited from using the cash portion of the EBT card at vendors and automatic teller machines located outside of Minnesota, Iowa, North Dakota, South Dakota, or Wisconsin. This subdivision does not apply to the food portion.

Sec. 6. Minnesota Statutes 2011 Supplement, section 256.987, is amended by adding a subdivision to read:

Subd. 4. **Disqualification.** (a) Any person found to be guilty of purchasing tobacco products or alcoholic beverages with their EBT debit card by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, in the: (1) Minnesota family investment program and any affiliated program to include the diversionary work program and the work participation cash benefit program under chapter 256J; (2) general assistance program under chapter 256D; or (3) Minnesota supplemental aid program under chapter 256D, shall be disqualified from all of the listed programs.

(b) The needs of the disqualified individual shall not be taken into consideration in determining the grant level for that assistance unit: (1) for one year after the first offense; (2) for two years after the second offense; and (3) permanently after the third or subsequent offense.

(c) The period of Program disqualification shall begin on the date stipulated on the advance notice of disqualification without possibility for postponement for administrative stay or administrative hearing and shall continue through completion unless and until the findings upon which the sanctions were imposed are reversed by a court of competent jurisdiction. The period for which sanctions are imposed is not subject to review.

EFFECTIVE DATE. This section is effective June 1, 2012.

Sec. 7. Minnesota Statutes 2010, section 256D.06, subdivision 1b, is amended to read:

Subd. 1b. **Earned income savings account.** In addition to the $50 disregard required under subdivision 1, the county agency shall disregard an additional earned income up to a maximum of ~~$150~~ $500 per month for: (1) persons residing in facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0690 and 9530.2500 to 9530.4000, and for whom discharge and work are part of a treatment plan; (2) persons living in supervised apartments with services funded under Minnesota Rules, parts 9535.0100 to 9535.1600, and for whom discharge and work are part of a treatment plan; and (3) persons residing in group residential housing, as that term is defined in section 256I.03, subdivision 3, for whom the county agency has approved a discharge plan which includes work. The additional amount disregarded must be placed in a separate savings account by the eligible individual, to be used upon discharge from the residential facility into the community. For individuals residing in a chemical dependency program licensed under Minnesota Rules, part 9530.4100, subpart 22, item D, withdrawals from the savings account require the signature of the individual and for those individuals with an authorized representative payee, the signature of the payee. A maximum of ~~$1,000~~ $2,000, including interest, of the money in the savings account must be excluded from the resource limits established by section 256D.08, subdivision 1, clause (1). Amounts in that account in excess of ~~$1,000~~ $2,000 must be applied to the resident's cost of care. If excluded money is removed from the savings account by the eligible individual at any time before the individual is discharged from the facility into the community, the money is income to the individual in the month of receipt and a resource in subsequent months. If an eligible individual moves from a community facility to an inpatient hospital setting, the separate savings account is an excluded asset for up to 18 months. During that time, amounts that accumulate in excess of the ~~$1,000~~ $2,000 savings limit must be applied to the patient's cost of care. If the patient continues to be hospitalized at the conclusion of the 18-month period, the entire account must be applied to the patient's cost of care.

Sec. 8. Minnesota Statutes 2011 Supplement, section 256E.35, subdivision 5, is amended to read:

Subd. 5. **Household eligibility; participation.** (a) To be eligible for state or TANF matching funds in the family assets for independence initiative, a household must meet the eligibility requirements of the federal Assets for Independence Act, Public Law 105-285, in Title IV, section 408 of that act.

(b) Each participating household must sign a family asset agreement that includes the amount of scheduled deposits into its savings account, the proposed use, and the

proposed savings goal. A participating household must agree to complete an economic literacy training program.

Participating households may only deposit money that is derived from household earned income or from state and federal income tax credits.

Sec. 9. Minnesota Statutes 2011 Supplement, section 256E.35, subdivision 6, is amended to read:

Subd. 6. **Withdrawal; matching; permissible uses.** (a) To receive a match, a participating household must transfer funds withdrawn from a family asset account to its matching fund custodial account held by the fiscal agent, according to the family asset agreement. The fiscal agent must determine if the match request is for a permissible use consistent with the household's family asset agreement.

The fiscal agent must ensure the household's custodial account contains the applicable matching funds to match the balance in the household's account, including interest, on at least a quarterly basis and at the time of an approved withdrawal. Matches must be provided as follows:

(1) from state grant and TANF funds, a matching contribution of $1.50 for every $1 of funds withdrawn from the family asset account equal to the lesser of $720 per year or a $3,000 lifetime limit; and

(2) from nonstate funds, a matching contribution of no less than $1.50 for every $1 of funds withdrawn from the family asset account equal to the lesser of $720 per year or a $3,000 lifetime limit.

(b) Upon receipt of transferred custodial account funds, the fiscal agent must make a direct payment to the vendor of the goods or services for the permissible use.

Sec. 10. Minnesota Statutes 2010, section 256E.37, subdivision 1, is amended to read:

Subdivision 1. **Grant authority.** The commissioner may make grants to state agencies and political subdivisions to construct or rehabilitate facilities for early childhood programs, crisis nurseries, or parenting time centers. The following requirements apply:

(1) The facilities must be owned by the state or a political subdivision, but may be leased under section 16A.695 to organizations that operate the programs. The commissioner must prescribe the terms and conditions of the leases.

(2) A grant for an individual facility must not exceed $500,000 for each program that is housed in the facility, up to a maximum of $2,000,000 for a facility that houses three programs or more. Programs include Head Start, School Readiness, Early Childhood Family Education, licensed child care, and other early childhood intervention programs.

(3) State appropriations must be matched on a 50 percent basis with nonstate funds. The matching requirement must apply program wide and not to individual grants.

(4) At least 80 percent of grant funds must be distributed to facilities located in counties not included in the definition under section 473.121, subdivision 4.

Sec. 11. Minnesota Statutes 2011 Supplement, section 256I.05, subdivision 1a, is amended to read:

Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04, subdivision 3, the county agency may negotiate a payment not to exceed $426.37 for other services necessary to provide room and board provided by the group residence if the residence is licensed by or registered by the Department of Health, or licensed by the Department of Human Services to provide services in addition to room and board, and if the provider of services is not also concurrently receiving funding for services for a recipient under a home and community-based waiver under title XIX of the Social Security Act; or funding from the medical assistance program under section 256B.0659, for personal care services for residents in the setting; or residing in a setting which receives funding under Minnesota Rules, parts 9535.2000 to 9535.3000. If funding is available for other necessary services through a home and community-based waiver, or personal care services under section 256B.0659, then the GRH rate is limited to the rate set in subdivision 1. Unless otherwise provided in law, in no case may the supplementary service rate exceed $426.37. The registration and licensure requirement does not apply to establishments which are exempt from state licensure because they are located on Indian reservations and for which the tribe has prescribed health and safety requirements. Service payments under this section may be prohibited under rules to prevent the supplanting of federal funds with state funds. The commissioner shall pursue the feasibility of obtaining the approval of the Secretary of Health and Human Services to provide home and community-based waiver services under title XIX of the Social Security Act for residents who are not eligible for an existing home and community-based waiver due to a primary diagnosis of mental illness or chemical dependency and shall apply for a waiver if it is determined to be cost-effective.

(b) The commissioner is authorized to make cost-neutral transfers from the GRH fund for beds under this section to other funding programs administered by the department after consultation with the county or counties in which the affected beds are located. The commissioner may also make cost-neutral transfers from the GRH fund to county human service agencies for beds permanently removed from the GRH census under a plan

submitted by the county agency and approved by the commissioner. The commissioner shall report the amount of any transfers under this provision annually to the legislature.

(c) The provisions of paragraph (b) do not apply to a facility that has its reimbursement rate established under section 256B.431, subdivision 4, paragraph (c).

(d) Counties must not negotiate supplementary service rates with providers of group residential housing that are licensed as board and lodging with special services and that do not encourage a policy of sobriety on their premises and make referrals to available community services for volunteer and employment opportunities for residents.

Sec. 12. Minnesota Statutes 2010, section 256I.05, subdivision 1e, is amended to read:

Subd. 1e. **Supplementary rate for certain facilities.** (a) Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2005, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $700 per month, including any legislatively authorized inflationary adjustments, for a group residential housing provider that:

(1) is located in Hennepin County and has had a group residential housing contract with the county since June 1996;

(2) operates in three separate locations a 75-bed facility, a 50-bed facility, and a 26-bed facility; and

(3) serves a chemically dependent clientele, providing 24 hours per day supervision and limiting a resident's maximum length of stay to 13 months out of a consecutive 24-month period.

(b) Notwithstanding subdivisions 1a and 1c, beginning July 1, 2013, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $700 per month, including any legislatively authorized inflationary adjustments, for the group residential provider described under paragraph (a), not to exceed an additional 175 beds.

EFFECTIVE DATE. This section is effective July 1, 2013.

Sec. 13. Minnesota Statutes 2010, section 256J.26, subdivision 1, is amended to read:

Subdivision 1. **Person convicted of drug offenses.** (a) ~~Applicants or participants~~ An individual who ~~have~~ has been convicted of a felony level drug offense committed ~~after July 1, 1997, may, if otherwise eligible, receive MFIP benefits subject to the following conditions:~~ during the previous ten years from the date of application or recertification is subject to the following:

(1) Benefits for the entire assistance unit must be paid in vendor form for shelter ~~and~~, utilities, and basic needs during any time the applicant is part of the assistance unit.

(2) The convicted applicant or participant shall be subject to random drug testing as a condition of continued eligibility and following any positive test for an illegal controlled substance is subject to the following sanctions:

(i) for failing a drug test the first time, the residual amount of the participant's grant after making vendor payments for shelter and utility costs, if any, must be reduced by an amount equal to 30 percent of the MFIP standard of need for an assistance unit of the same size. When a sanction under this subdivision is in effect, the job counselor must attempt to meet with the person face-to-face. During the face-to-face meeting, the job counselor must explain the consequences of a subsequent drug test failure and inform the participant of the right to appeal the sanction under section 256J.40. If a face-to-face meeting is not possible, the county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting; or

(ii) for failing a drug test two times, the participant is permanently disqualified from receiving MFIP assistance, both the cash and food portions. The assistance unit's MFIP grant must be reduced by the amount which would have otherwise been made available to the disqualified participant. Disqualification under this item does not make a participant ineligible for food stamps or food support. Before a disqualification under this provision is imposed, the job counselor must attempt to meet with the participant face-to-face. During the face-to-face meeting, the job counselor must identify other resources that may be available to the participant to meet the needs of the family and inform the participant of the right to appeal the disqualification under section 256J.40. If a face-to-face meeting is not possible, the county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting.

(3) A participant who fails a drug test the first time and is under a sanction due to other MFIP program requirements is considered to have more than one occurrence of noncompliance and is subject to the applicable level of sanction as specified under section 256J.46, subdivision 1, paragraph (d).

(b) Applicants requesting only food stamps or food support or participants receiving only food stamps or food support, who have been convicted of a drug offense that occurred after July 1, 1997, may, if otherwise eligible, receive food stamps or food support if the convicted applicant or participant is subject to random drug testing as a condition

of continued eligibility. Following a positive test for an illegal controlled substance, the applicant is subject to the following sanctions:

(1) for failing a drug test the first time, food stamps or food support shall be reduced by an amount equal to 30 percent of the applicable food stamp or food support allotment. When a sanction under this clause is in effect, a job counselor must attempt to meet with the person face-to-face. During the face-to-face meeting, a job counselor must explain the consequences of a subsequent drug test failure and inform the participant of the right to appeal the sanction under section 256J.40. If a face-to-face meeting is not possible, a county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting; and

(2) for failing a drug test two times, the participant is permanently disqualified from receiving food stamps or food support. Before a disqualification under this provision is imposed, a job counselor must attempt to meet with the participant face-to-face. During the face-to-face meeting, the job counselor must identify other resources that may be available to the participant to meet the needs of the family and inform the participant of the right to appeal the disqualification under section 256J.40. If a face-to-face meeting is not possible, a county agency must send the participant a notice of adverse action as provided in section 256J.31, subdivisions 4 and 5, and must include the information required in the face-to-face meeting.

~~(c)~~ (b) For the purposes of this subdivision, "drug offense" means an offense that occurred ~~after July 1, 1997,~~ during the previous ten years from the date of application or recertification of sections 152.021 to 152.025, 152.0261, 152.0262, ~~or~~ 152.096, or 152.137. Drug offense also means a conviction in another jurisdiction of the possession, use, or distribution of a controlled substance, or conspiracy to commit any of these offenses, if the offense occurred ~~after July 1, 1997,~~ during the previous ten years from the date of application or recertification and the conviction is a felony offense in that jurisdiction, or in the case of New Jersey, a high misdemeanor.

EFFECTIVE DATE. This section is effective July 1, 2012, for all new MFIP applicants who apply on or after that date and for all recertifications occurring on or after that date.

Sec. 14. Minnesota Statutes 2010, section 256J.26, is amended by adding a subdivision to read:

Subd. 5. **Vendor payment; uninhabitable units.** Upon discovery by the county that a unit has been deemed uninhabitable under section 504B.131, the county shall

immediately notify the landlord to return the vendor paid rent under this section for the month in which the discovery occurred. The county shall cease future rent payments until the landlord demonstrates the premises are fit for the intended use. A landlord who is required to return vendor paid rent or is prohibited from receiving future rent under this subdivision may not take an eviction action against anyone in the assistance unit.

Sec. 15. **GRANT PROGRAM TO PROMOTE HEALTHY COMMUNITY INITIATIVES.**

(a) The commissioner of human services must contract with the Search Institute to help local communities develop, expand, and maintain the tools, training, and resources needed to foster positive community development and effectively engage people in their community. The Search Institute must: (1) provide training in community mobilization, youth development, and assets getting to outcomes; (2) provide ongoing technical assistance to communities receiving grants under this section; (3) use best practices to promote community development; (4) share best program practices with other interested communities; (5) create electronic and other opportunities for communities to share experiences in and resources for promoting healthy community development; and (6) provide an annual report of the strong communities project.

(b) Specifically, the Search Institute must use a competitive grant process to select four interested communities throughout Minnesota to undertake strong community mobilization initiatives to support communities wishing to catalyze multiple sectors to create or strengthen a community collaboration to address issues of poverty in their communities. The Search Institute must provide the selected communities with the tools, training, and resources they need for successfully implementing initiatives focused on strengthening the community. The Search Institute also must use a competitive grant process to provide four strong community innovation grants to encourage current community initiatives to bring new innovation approaches to their work to reduce poverty. Finally, the Search Institute must work to strengthen networking and information sharing activities among all healthy community initiatives throughout Minnesota, including sharing best program practices and providing personal and electronic opportunities for peer learning and ongoing program support.

(c) In order to receive a grant under paragraph (b), a community must show involvement of at least three sectors of their community and the active leadership of both youth and adults. Sectors may include, but are not limited to, local government, schools, community action agencies, faith communities, businesses, higher education institutions, and the medical community. In addition, communities must agree to: (1) attend training

on community mobilization processes and strength-based approaches; (2) apply the assets getting to outcomes process in their initiative; (3) meet at least two times during the grant period to share successes and challenges with other grantees; (4) participate on an electronic listserv to share information throughout the period on their work; and (5) all communication requirements and reporting processes.

(d) The commissioner of human services must evaluate the effectiveness of this program and must recommend to the committees of the legislature with jurisdiction over health and human services reform and finance by February 15, 2013, whether or not to make the program available statewide. The Search Institute annually must report to the commissioner of human services on the services it provided and the grant money it expended under this section.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 16. **CIRCLES OF SUPPORT GRANTS.**

The commissioner of human services must provide grants to community action agencies to help local communities develop, expand, and maintain the tools, training, and resources needed to foster social assets to assist people out of poverty through circles of support. The circles of support model must provide a framework for a community to build relationships across class and race lines so that people can work together to advocate for change in their communities and move individuals toward self-sufficiency.

Specifically, circles of support initiatives must focus on increasing social capital, income, educational attainment, and individual accountability, while reducing debt, service dependency, and addressing systemic disparities that hold poverty in place. The effort must support the development of local guiding coalitions as the link between the community and circles of support for resource development and funding leverage.

EFFECTIVE DATE. This section is effective July 1, 2012.

Sec. 17. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall change the term "assistance transaction card" or similar terms to "electronic benefit transaction" or similar terms wherever they appear in Minnesota Statutes, chapter 256. The revisor may make changes necessary to correct the punctuation, grammar, or structure of the remaining text and preserve its meaning.

ARTICLE 4

CONTINUING CARE

Section 1. Minnesota Statutes 2010, section 144A.351, is amended to read:

144A.351 BALANCING LONG-TERM CARE SERVICES AND SUPPORTS: REPORT REQUIRED.

The commissioners of health and human services, in consultation with ~~the cooperation of counties and~~ stakeholders, including persons who need or are using long-term care services and supports, lead agencies, regional entities, senior and disability organization representatives, service providers, community members, including local businesses, and faith-based representatives shall prepare a report to the legislature by August 15, ~~2004~~ 2013, and biennially thereafter, regarding the status of the full range of long-term care services and supports for the elderly and children and adults with disabilities in Minnesota. The report shall address:

(1) demographics and need for long-term care services and supports in Minnesota;

(2) summary of county and regional reports on long-term care gaps, surpluses, imbalances, and corrective action plans;

(3) status of long-term care services by county and region including:

(i) changes in availability of the range of long-term care services and housing options;

(ii) access problems regarding long-term care services; and

(iii) comparative measures of long-term care services availability and ~~progress~~ changes over time; and

(4) recommendations regarding goals for the future of long-term care services and supports, policy and fiscal changes, and resource needs.

Sec. 2. Minnesota Statutes 2011 Supplement, section 245A.03, subdivision 7, is amended to read:

Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location that will not be the primary residence of the license holder for the entire period of licensure. If a license is issued during this moratorium, and the license holder changes the license holder's primary residence away from the physical location of the foster care license, the commissioner shall revoke the license according to section 245A.07. Exceptions to the moratorium include:

(1) foster care settings that are required to be registered under chapter 144D;

(2) foster care licenses replacing foster care licenses in existence on May 15, 2009, and determined to be needed by the commissioner under paragraph (b);

(3) new foster care licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/MR, or regional treatment center, or restructuring of state-operated services that limits the capacity of state-operated facilities;

(4) new foster care licenses determined to be needed by the commissioner under paragraph (b) for persons requiring hospital level care; or

(5) new foster care licenses determined to be needed by the commissioner for the transition of people from personal care assistance to the home and community-based services.

(b) The commissioner shall determine the need for newly licensed foster care homes as defined under this subdivision using the resource need determination process described in paragraph (f). As part of the determination, the commissioner shall consider the availability of foster care capacity in the area in which the licensee seeks to operate, ~~and the recommendation of the local county board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address~~ and other data and information, including the report on the status of long-term care services, required under section 144A.351.

(c) Residential settings that would otherwise be subject to the moratorium established in paragraph (a), that are in the process of receiving an adult or child foster care license as of July 1, 2009, shall be allowed to continue to complete the process of receiving an adult or child foster care license. For this paragraph, all of the following conditions must be met to be considered in the process of receiving an adult or child foster care license:

(1) participants have made decisions to move into the residential setting, including documentation in each participant's care plan;

(2) the provider has purchased housing or has made a financial investment in the property;

(3) the lead agency has approved the plans, including costs for the residential setting for each individual;

(4) the completion of the licensing process, including all necessary inspections, is the only remaining component prior to being able to provide services; and

(5) the needs of the individuals cannot be met within the existing capacity in that county.

To qualify for the process under this paragraph, the lead agency must submit documentation to the commissioner by August 1, 2009, that all of the above criteria are met.

(d) The commissioner shall study the effects of the license moratorium under this subdivision and shall report back to the legislature by January 15, 2011. This study shall include, but is not limited to the following:

(1) the overall capacity and utilization of foster care beds where the physical location is not the primary residence of the license holder prior to and after implementation of the moratorium;

(2) the overall capacity and utilization of foster care beds where the physical location is the primary residence of the license holder prior to and after implementation of the moratorium; and

(3) the number of licensed and occupied ICF/MR beds prior to and after implementation of the moratorium.

(e) When a foster care recipient moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), the county shall immediately inform the Department of Human Services Licensing Division~~, and~~. The department shall ~~immediately~~ decrease the licensed capacity ~~for the home~~ of foster care settings where the physical location is not the primary residence of the license holder if the voluntary changes described in paragraph (f) are not sufficient to meet the savings required by 2011 reductions in licensed bed capacity and maintain statewide long-term care residential services capacity within budgetary limits. If a licensed adult foster home becomes no longer viable, the lead agency, with the assistance of the department, shall facilitate a consolidation of settings or closure. A decreased licensed capacity according to this paragraph is not subject to appeal under this chapter.

(f) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity required under paragraph (e), will occur. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet long-term care service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long-term care services reports and statewide data and information. By February 1 of each year, the commissioner shall provide information and data on the overall capacity of licensed long-term care services, actions taken under this subdivision to manage statewide long-term care services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over the health and human services budget.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 3. Minnesota Statutes 2010, section 252.27, subdivision 2a, is amended to read:

Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child, including a child determined eligible for medical assistance without consideration of parental income, must contribute to the cost of services used by making monthly payments on a sliding scale based on income, unless the child is married or has been married, parental rights have been terminated, or the child's adoption is subsidized according to section 259.67 or through title IV-E of the Social Security Act. The parental contribution is a partial or full payment for medical services provided for diagnostic, therapeutic, curing, treating, mitigating, rehabilitation, maintenance, and personal care services as defined in United States Code, title 26, section 213, needed by the child with a chronic illness or disability.

(b) For households with adjusted gross income equal to or greater than 100 percent of federal poverty guidelines, the parental contribution shall be computed by applying the following schedule of rates to the adjusted gross income of the natural or adoptive parents:

(1) if the adjusted gross income is equal to or greater than 100 percent of federal poverty guidelines and less than 175 percent of federal poverty guidelines, the parental contribution is $4 per month;

(2) if the adjusted gross income is equal to or greater than 175 percent of federal poverty guidelines and less than or equal to ~~545~~ 525 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at one percent of adjusted gross income at 175 percent of federal poverty guidelines and increases to ~~7.5~~ eight percent of adjusted gross income for those with adjusted gross income up to ~~545~~ 525 percent of federal poverty guidelines;

(3) if the adjusted gross income is greater than ~~545~~ 525 percent of federal poverty guidelines and less than 675 percent of federal poverty guidelines, the parental contribution shall be ~~7.5~~ 9.5 percent of adjusted gross income;

(4) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than ~~975~~ 900 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at ~~7.5~~ 9.5 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to ~~ten~~ 12 percent of adjusted gross income for those with adjusted gross income up to ~~975~~ 900 percent of federal poverty guidelines; and

(5) if the adjusted gross income is equal to or greater than ~~975~~ 900 percent of federal poverty guidelines, the parental contribution shall be ~~12.5~~ 13.5 percent of adjusted gross income.

If the child lives with the parent, the annual adjusted gross income is reduced by $2,400 prior to calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

(c) The household size to be used in determining the amount of contribution under paragraph (b) includes natural and adoptive parents and their dependents, including the child receiving services. Adjustments in the contribution amount due to annual changes in the federal poverty guidelines shall be implemented on the first day of July following publication of the changes.

(d) For purposes of paragraph (b), "income" means the adjusted gross income of the natural or adoptive parents determined according to the previous year's federal tax form, except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds have been used to purchase a home shall not be counted as income.

(e) The contribution shall be explained in writing to the parents at the time eligibility for services is being determined. The contribution shall be made on a monthly basis effective with the first month in which the child receives services. Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of services provided, the local agency or the state shall reimburse that excess amount to the parents, either by direct reimbursement if the parent is no longer required to pay a contribution, or by a reduction in or waiver of parental fees until the excess amount is exhausted. All reimbursements must include a notice that the amount reimbursed may be taxable income if the parent paid for the parent's fees through an employer's health care flexible spending account under the Internal Revenue Code, section 125, and that the parent is responsible for paying the taxes owed on the amount reimbursed.

(f) The monthly contribution amount must be reviewed at least every 12 months; when there is a change in household size; and when there is a loss of or gain in income from one month to another in excess of ten percent. The local agency shall mail a written notice 30 days in advance of the effective date of a change in the contribution amount. A decrease in the contribution amount is effective in the month that the parent verifies a reduction in income or change in household size.

(g) Parents of a minor child who do not live with each other shall each pay the contribution required under paragraph (a). An amount equal to the annual court-ordered child support payment actually paid on behalf of the child receiving services shall be

deducted from the adjusted gross income of the parent making the payment prior to calculating the parental contribution under paragraph (b).

(h) The contribution under paragraph (b) shall be increased by an additional five percent if the local agency determines that insurance coverage is available but not obtained for the child. For purposes of this section, "available" means the insurance is a benefit of employment for a family member at an annual cost of no more than five percent of the family's annual income. For purposes of this section, "insurance" means health and accident insurance coverage, enrollment in a nonprofit health service plan, health maintenance organization, self-insured plan, or preferred provider organization.

Parents who have more than one child receiving services shall not be required to pay more than the amount for the child with the highest expenditures. There shall be no resource contribution from the parents. The parent shall not be required to pay a contribution in excess of the cost of the services provided to the child, not counting payments made to school districts for education-related services. Notice of an increase in fee payment must be given at least 30 days before the increased fee is due.

(i) The contribution under paragraph (b) shall be reduced by $300 per fiscal year if, in the 12 months prior to July 1:

(1) the parent applied for insurance for the child;

(2) the insurer denied insurance;

(3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a complaint or appeal, in writing, to the commissioner of health or the commissioner of commerce, or litigated the complaint or appeal; and

(4) as a result of the dispute, the insurer reversed its decision and granted insurance.

For purposes of this section, "insurance" has the meaning given in paragraph (h).

A parent who has requested a reduction in the contribution amount under this paragraph shall submit proof in the form and manner prescribed by the commissioner or county agency, including, but not limited to, the insurer's denial of insurance, the written letter or complaint of the parents, court documents, and the written response of the insurer approving insurance. The determinations of the commissioner or county agency under this paragraph are not rules subject to chapter 14.

~~(j) Notwithstanding paragraph (b), for the period from July 1, 2010, to June 30, 2013, the parental contribution shall be computed by applying the following contribution schedule to the adjusted gross income of the natural or adoptive parents:~~

~~(1) if the adjusted gross income is equal to or greater than 100 percent of federal poverty guidelines and less than 175 percent of federal poverty guidelines, the parental contribution is $4 per month;~~

~~(2) if the adjusted gross income is equal to or greater than 175 percent of federal poverty guidelines and less than or equal to 525 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at one percent of adjusted gross income at 175 percent of federal poverty guidelines and increases to eight percent of adjusted gross income for those with adjusted gross income up to 525 percent of federal poverty guidelines;~~

~~(3) if the adjusted gross income is greater than 525 percent of federal poverty guidelines and less than 675 percent of federal poverty guidelines, the parental contribution shall be 9.5 percent of adjusted gross income;~~

~~(4) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 900 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at 9.5 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to 12 percent of adjusted gross income for those with adjusted gross income up to 900 percent of federal poverty guidelines; and~~

~~(5) if the adjusted gross income is equal to or greater than 900 percent of federal poverty guidelines, the parental contribution shall be 13.5 percent of adjusted gross income. If the child lives with the parent, the annual adjusted gross income is reduced by $2,400 prior to calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.~~

Sec. 4. Minnesota Statutes 2011 Supplement, section 256.045, subdivision 3, is amended to read:

Subd. 3. **State agency hearings.** (a) State agency hearings are available for the following:

(1) any person applying for, receiving or having received public assistance, medical care, or a program of social services granted by the state agency or a county agency or the federal Food Stamp Act whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid;

(2) any patient or relative aggrieved by an order of the commissioner under section 252.27;

(3) a party aggrieved by a ruling of a prepaid health plan;

(4) except as provided under chapter 245C, any individual or facility determined by a lead investigative agency to have maltreated a vulnerable adult under section 626.557 after they have exercised their right to administrative reconsideration under section 626.557;

(5) any person whose claim for foster care payment according to a placement of the child resulting from a child protection assessment under section 626.556 is denied or not acted upon with reasonable promptness, regardless of funding source;

(6) any person to whom a right of appeal according to this section is given by other provision of law;

(7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15;

(8) an applicant aggrieved by an adverse decision to an application or redetermination for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a;

(9) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under section 626.556, after the individual or facility has exercised the right to administrative reconsideration under section 626.556;

(10) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, following a reconsideration decision issued under section 245C.23, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (9) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services referee shall include both the maltreatment determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment. Individuals and organizations specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause why the request was not submitted within the 30-day time limit; or

(11) any person with an outstanding debt resulting from receipt of public assistance, medical care, or the federal Food Stamp Act who is contesting a setoff claim by the

Department of Human Services or a county agency. The scope of the appeal is the validity of the claimant agency's intention to request a setoff of a refund under chapter 270A against the debt.

(b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or (10), is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under paragraph (a), clause (9), is only available when there is no juvenile court or adult criminal action pending. If such action is filed in either court while an administrative review is pending, the administrative review must be suspended until the judicial actions are completed. If the juvenile court action or criminal charge is dismissed or the criminal action overturned, the matter may be considered in an administrative hearing.

(c) For purposes of this section, bargaining unit grievance procedures are not an administrative appeal.

(d) The scope of hearings involving claims to foster care payments under paragraph (a), clause (5), shall be limited to the issue of whether the county is legally responsible for a child's placement under court order or voluntary placement agreement and, if so, the correct amount of foster care payment to be made on the child's behalf and shall not include review of the propriety of the county's child protection determination or child placement decision.

(e) The scope of hearings involving appeals related to the reduction, suspension, denial, or termination of personal care assistance services under section 256B.0659 shall be limited to the specific issues under written appeal.

(f) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 4.

~~(f)~~ (g) An applicant or recipient is not entitled to receive social services beyond the services prescribed under chapter 256M or other social services the person is eligible for under state law.

~~(g)~~ (h) The commissioner may summarily affirm the county or state agency's proposed action without a hearing when the sole issue is an automatic change due to a change in state or federal law.

EFFECTIVE DATE. This section is effective for all notices of action dated on or after July 1, 2012.

Sec. 5. Minnesota Statutes 2010, section 256B.056, subdivision 1a, is amended to read:

Subd. 1a. **Income and assets generally.** Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the supplemental security income program shall be used, except as provided under subdivision 3, paragraph (a), clause (6). Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year. Effective upon federal approval, for children eligible under section 256B.055, subdivision 12, or for home and community-based waiver services whose eligibility for medical assistance is determined without regard to parental income, child support payments, including any payments made by an obligor in satisfaction of or in addition to a temporary or permanent order for child support, and Social Security payments are not counted as income. For families and children, which includes all other eligibility categories, the methodologies under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, shall be used, except that effective October 1, 2003, the earned income disregards and deductions are limited to those in subdivision 1c. For these purposes, a "methodology" does not include an asset or income standard, or accounting method, or method of determining effective dates.

EFFECTIVE DATE. This section is effective April 1, 2012.

Sec. 6. Minnesota Statutes 2011 Supplement, section 256B.056, subdivision 3, is amended to read:

Subd. 3. **Asset limitations for individuals and families.** (a) To be eligible for medical assistance, a person must not individually own more than $3,000 in assets, or if a member of a household with two family members, husband and wife, or parent and child, the household must not own more than $6,000 in assets, plus $200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family

may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

(1) household goods and personal effects are not considered;

(2) capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered;

(3) motor vehicles are excluded to the same extent excluded by the supplemental security income program;

(4) assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses; ~~and~~

(5) for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (d)~~.~~; and

(6) when a person enrolled in medical assistance under section 256B.057, subdivision 9, is age 65 or older and has been enrolled during each of the 24 consecutive months before the person's 65th birthday, the assets owned by the person and the person's spouse must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when determining eligibility for medical assistance under section 256B.055, subdivision 7. The income of a spouse of a person enrolled in medical assistance under section 256B.057, subdivision 9, during each of the 24 consecutive months before the person's 65th birthday must be disregarded when determining eligibility for medical assistance under section 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions in section 256B.059. A person whose 65th birthday occurs in 2012 or 2013 is required to have qualified for medical assistance under section 256B.057, subdivision 9, prior to age 65 for at least 20 months in the 24 months prior to reaching age 65.

(b) No asset limit shall apply to persons eligible under section 256B.055, subdivision 15.

EFFECTIVE DATE. This section is effective April 1, 2012.

Sec. 7. Minnesota Statutes 2011 Supplement, section 256B.057, subdivision 9, is amended to read:

Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid for a person who is employed and who:

(1) but for excess earnings or assets, meets the definition of disabled under the Supplemental Security Income program;

(2) ~~is at least 16 but less than 65 years of age;~~

~~(3)~~ meets the asset limits in paragraph (d); and

~~(4)~~ (3) pays a premium and other obligations under paragraph (e).

(b) For purposes of eligibility, there is a $65 earned income disregard. To be eligible for medical assistance under this subdivision, a person must have more than $65 of earned income. Earned income must have Medicare, Social Security, and applicable state and federal taxes withheld. The person must document earned income tax withholding. Any spousal income or assets shall be disregarded for purposes of eligibility and premium determinations.

(c) After the month of enrollment, a person enrolled in medical assistance under this subdivision who:

(1) is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician; or

(2) loses employment for reasons not attributable to the enrollee, and is without receipt of earned income may retain eligibility for up to four consecutive months after the month of job loss. To receive a four-month extension, enrollees must verify the medical condition or provide notification of job loss. All other eligibility requirements must be met and the enrollee must pay all calculated premium costs for continued eligibility.

(d) For purposes of determining eligibility under this subdivision, a person's assets must not exceed $20,000, excluding:

(1) all assets excluded under section 256B.056;

(2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, and pension plans;

(3) medical expense accounts set up through the person's employer; and

(4) spousal assets, including spouse's share of jointly held assets.

(e) All enrollees must pay a premium to be eligible for medical assistance under this subdivision, except as provided under section 256.01, subdivision 18b.

(1) An enrollee must pay the greater of a $65 premium or the premium calculated based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines.

(2) Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.

(3) All enrollees who receive unearned income must pay five percent of unearned income in addition to the premium amount, except as provided under section 256.01, subdivision 18b.

(4) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

(f) A person's eligibility and premium shall be determined by the local county agency. Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.

(g) Any required premium shall be determined at application and redetermined at the enrollee's six-month income review or when a change in income or household size is reported. Enrollees must report any change in income or household size within ten days of when the change occurs. A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next six-month review.

(h) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.

(i) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. Good cause exists if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to D, are met. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

(j) The commissioner shall notify enrollees annually beginning at least 24 months before the person's 65th birthday of the medical assistance eligibility rules affecting income, assets, and treatment of a spouse's income and assets that will be applied upon reaching age 65.

(k) For enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the commissioner shall reimburse the enrollee for Medicare part B premiums under section 256B.0625, subdivision 15, paragraph (a).

EFFECTIVE DATE. This section is effective April 1, 2012.

Sec. 8. Minnesota Statutes 2010, section 256B.0659, is amended by adding a subdivision to read:

Subd. 31. **Appeals.** (a) A recipient who is adversely affected by the reduction, suspension, denial, or termination of services under this section may appeal the decision according to section 256.045. The notice of the reduction, suspension, denial, or termination of services from the lead agency to the applicant or recipient must be made in plain language and must include a form for written appeal. The commissioner may provide lead agencies with a model form for written appeal. The appeal must be in writing and identify the specific issues the recipient would like to have considered in the appeal hearing and a summary of the basis, with supporting professional documentation if available, for contesting the decision.

(b) If a recipient has a change in condition or new information after the date of the assessment, temporary services may be authorized according to section 256B.0652, subdivision 9, until a new assessment is completed.

Sec. 9. Minnesota Statutes 2011 Supplement, section 256B.0911, subdivision 3a, is amended to read:

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living, including persons who need assessment in order to determine waiver or alternative care program eligibility, must be visited by a long-term care consultation team within 15 calendar days after the date on which an assessment was requested or recommended. After January 1, 2011, these requirements also apply to personal care assistance services, private duty nursing, and home health agency services, on timelines established in subdivision 5. Face-to-face assessments must be conducted according to paragraphs (b) to (i).

(b) The county may utilize a team of either the social worker or public health nurse, or both. After January 1, 2011, lead agencies shall use certified assessors to conduct the assessment in a face-to-face interview. The consultation team members must confer regarding the most appropriate care for each individual screened or assessed.

(c) The assessment must be comprehensive and include a person-centered assessment of the health, psychological, functional, environmental, and social needs of referred individuals and provide information necessary to develop a support plan that meets the consumers needs, using an assessment form provided by the commissioner.

(d) The assessment must be conducted in a face-to-face interview with the person being assessed and the person's legal representative, as required by legally executed documents, and other individuals as requested by the person, who can provide information on the needs, strengths, and preferences of the person necessary to develop a support plan that ensures the person's health and safety, but who is not a provider of service or has any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living services under section 256B.0915, with the permission of the person being assessed or the persons' designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining their recommendations regarding the client's care needs. The person conducting the assessment will notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment and must be considered prior to the finalization of the assessment.

(e) The person, or the person's legal representative, must be provided with written recommendations for community-based services, including consumer-directed options, or institutional care that include documentation that the most cost-effective alternatives available were offered to the individual, and alternatives to residential settings, including, but not limited to, foster care settings that are not the primary residence of the license holder. For purposes of this requirement, "cost-effective alternatives" means community services and living arrangements that cost the same as or less than institutional care.

(f) If the person chooses to use community-based services, the person or the person's legal representative must be provided with a written community support plan, regardless of whether the individual is eligible for Minnesota health care programs. A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to the services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

(g) The person has the right to make the final decision between institutional placement and community placement after the recommendations have been provided, except as provided in subdivision 4a, paragraph (c).

(h) The team must give the person receiving assessment or support planning, or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

(1) the need for and purpose of preadmission screening if the person selects nursing facility placement;

(2) the role of the long-term care consultation assessment and support planning in waiver and alternative care program eligibility determination;

(3) information about Minnesota health care programs;

(4) the person's freedom to accept or reject the recommendations of the team;

(5) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;

(6) the long-term care consultant's decision regarding the person's need for institutional level of care as determined under criteria established in section 144.0724, subdivision 11, or 256B.092; and

(7) the person's right to appeal the decision regarding the need for nursing facility level of care or the county's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

(i) Face-to-face assessment completed as part of eligibility determination for the alternative care, elderly waiver, community alternatives for disabled individuals, community alternative care, and traumatic brain injury waiver programs under sections 256B.0915, 256B.0917, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment. The effective eligibility start date for these programs can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated in a face-to-face visit and documented in the department's Medicaid Management Information System (MMIS). The effective date of program eligibility in this case cannot be prior to the date the updated assessment is completed.

Sec. 10. Minnesota Statutes 2011 Supplement, section 256B.0911, subdivision 3c, is amended to read:

Subd. 3c. **Consultation for housing with services.** (a) The purpose of long-term care consultation for registered housing with services is to support persons with current or

anticipated long-term care needs in making informed choices among options that include the most cost-effective and least restrictive settings. Prospective residents maintain the right to choose housing with services or assisted living if that option is their preference.

(b) Registered housing with services establishments shall inform all prospective residents of the availability of long-term care consultation and the need to receive and verify the consultation prior to signing a lease or contract. Long-term care consultation for registered housing with services is provided as determined by the commissioner of human services. The service is delivered under a partnership between lead agencies as defined in subdivision 1a, paragraph (d), and the Area Agencies on Aging, and is a point of entry to a combination of telephone-based long-term care options counseling provided by Senior LinkAge Line and in-person long-term care consultation provided by lead agencies. The point of entry service must be provided within five working days of the request of the prospective resident as follows:

(1) the consultation shall be performed in a manner that provides objective and complete information;

(2) the consultation must include a review of the prospective resident's reasons for considering housing with services, the prospective resident's personal goals, a discussion of the prospective resident's immediate and projected long-term care needs, and alternative community services or housing with services settings that may meet the prospective resident's needs;

(3) the prospective resident shall be informed of the availability of a face-to-face visit at no charge to the prospective resident to assist the prospective resident in assessment and planning to meet the prospective resident's long-term care needs; and

(4) verification of counseling shall be generated and provided to the prospective resident by Senior LinkAge Line upon completion of the telephone-based counseling.

(c) Housing with services establishments registered under chapter 144D shall:

(1) inform all prospective residents of the availability of and contact information for consultation services under this subdivision;

(2) except for individuals seeking lease-only arrangements in subsidized housing settings, receive a copy of the verification of counseling prior to executing a lease or service contract with the prospective resident, and prior to executing a service contract with individuals who have previously entered into lease-only arrangements; and

(3) retain a copy of the verification of counseling as part of the resident's file.

(d) Exemptions from the consultation requirement under paragraph (b) and emergency admissions to registered housing with services establishments prior to

consultation under paragraph (b) are permitted according to policies established by the commissioner.

(e) Prospective residents who have used financial planning services and created a long-term care plan in the 12 months prior to signing a lease or contract with a registered housing with services or assisted living establishment are exempt from the long-term care consultation requirements under this subdivision. Housing with services establishments registered under chapter 144D are exempt from the requirements of paragraph (c), clauses (2) and (3), for prospective residents who are exempt from the requirements of this subdivision.

Sec. 11. Minnesota Statutes 2011 Supplement, section 256B.0915, subdivision 3e, is amended to read:

Subd. 3e. **Customized living service rate.** (a) Payment for customized living services shall be a monthly rate authorized by the lead agency within the parameters established by the commissioner. The payment agreement must delineate the amount of each component service included in the recipient's customized living service plan. The lead agency, with input from the provider of customized living services, shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized.

(b) The payment rate must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes shall use tools issued by the commissioner to develop and document customized living service plans and rates.

(c) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale. Customized living services must not include rent or raw food costs.

(d) With the exception of individuals described in subdivision 3a, paragraph (b), the individualized monthly authorized payment for the customized living service plan shall not exceed 50 percent of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home

rate determination is implemented and July 1 of each subsequent state fiscal year, the individualized monthly authorized payment for the services described in this clause shall not exceed the limit which was in effect on June 30 of the previous state fiscal year updated annually based on legislatively adopted changes to all service rate maximums for home and community-based service providers.

(e) Effective July 1, 2011, the individualized monthly payment for the customized living service plan for individuals described in subdivision 3a, paragraph (b), must be the monthly authorized payment limit for customized living for individuals classified as case mix A, reduced by 25 percent. This rate limit must be applied to all new participants enrolled in the program on or after July 1, 2011, who meet the criteria described in subdivision 3a, paragraph (b). This monthly limit also applies to all other participants who meet the criteria described in subdivision 3a, paragraph (b), at reassessment.

(f) Customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D. All customized living service participants must have a private bedroom unless they choose to share a bedroom with no more than one other family member, except for participants who live in a customized living setting that limits participants to two people per unit. Licensed home care providers are subject to section 256B.0651, subdivision 14.

(g) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph (d), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

Sec. 12. Minnesota Statutes 2010, section 256B.0915, subdivision 3g, is amended to read:

Subd. 3g. **Service rate limits; state assumption of costs.** (a) To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver, the commissioner shall establish statewide maximum service rate limits and eliminate lead agency-specific service rate limits.

(b) Effective July 1, 2001, for service rate limits, except those described or defined in subdivisions 3d and 3e, the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.

(c) Lead agencies may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.

(d) Notwithstanding the requirements of paragraphs (a) through (c), or the requirements in subdivisions 3e and 3h, and as part of waiver reform proposals developed under authority in section 256B.021, subdivision 4, paragraphs (f) and (g), the commissioner may develop proposals for alternative or enhanced service payment rate systems for purposes of ensuring reasonable and adequate access to home and community-based services for elderly waiver participants throughout the state based on criteria established to designate areas as critical access home and community-based service areas. These proposals, to be submitted to the legislature no later than February 15, 2013, must be based on an evaluation of statewide capacity and the determination of critical access home and community-based services areas. Alternative or enhanced service payment rate systems will be limited to providers delivering services to individuals residing in communities, counties, or groups of counties designated as critical access areas for home and community-based services. The commissioner shall consult with stakeholders who authorize and provide elderly waiver services as well as with consumer advocates and the ombudsman for long-term care.

(1) Alternative or enhanced payment rate systems may be developed in designated areas for elderly waiver services providers that may include:

(i) licensed home care providers qualified to enroll in Minnesota health care programs that are delivering services in housing with services establishments in critical access areas of the state;

(ii) providers as described in subdivision 3h, paragraph (g). Any calculation of an enhanced or alternative service rate under item 2, clauses (i) and (ii), must be limited to services only and cannot include rent, utilities, raw food, or nonallowable service component costs or charges; and

(iii) other nonresidential elderly waiver services.

(2) In order to develop critical access criteria and alternative or enhanced payment systems for critical access home and community-based services areas, the commissioner shall utilize information available from existing sources whenever possible.

(3) Providers applying for alternative or enhanced rates in critical access areas may be required to provide additional information as recommended by the commissioner and approved by the legislature.

Sec. 13. Minnesota Statutes 2011 Supplement, section 256B.0915, subdivision 3h, is amended to read:

Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The payment rate for 24-hour customized living services is a monthly rate authorized by the

lead agency within the parameters established by the commissioner of human services. The payment agreement must delineate the amount of each component service included in each recipient's customized living service plan. The lead agency, with input from the provider of customized living services, shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized. The lead agency shall not authorize 24-hour customized living services unless there is a documented need for 24-hour supervision.

(b) For purposes of this section, "24-hour supervision" means that the recipient requires assistance due to needs related to one or more of the following:

(1) intermittent assistance with toileting, positioning, or transferring;

(2) cognitive or behavioral issues;

(3) a medical condition that requires clinical monitoring; or

(4) for all new participants enrolled in the program on or after July 1, 2011, and all other participants at their first reassessment after July 1, 2011, dependency in at least three of the following activities of daily living as determined by assessment under section 256B.0911: bathing; dressing; grooming; walking; or eating when the dependency score in eating is three or greater; and needs medication management and at least 50 hours of service per month. The lead agency shall ensure that the frequency and mode of supervision of the recipient and the qualifications of staff providing supervision are described and meet the needs of the recipient.

(c) The payment rate for 24-hour customized living services must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes will use tools issued by the commissioner to develop and document customized living plans and authorize rates.

(d) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale.

(e) The individually authorized 24-hour customized living payments, in combination with the payment for other elderly waiver services, including case management, must not exceed the recipient's community budget cap specified in subdivision 3a. Customized living services must not include rent or raw food costs.

(f) The individually authorized 24-hour customized living payment rates shall not exceed the 95 percentile of statewide monthly authorizations for 24-hour customized living services in effect and in the Medicaid management information systems on March 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0050 to 9549.0059, to which elderly waiver service clients are assigned. When there are fewer than 50 authorizations in effect in the case mix resident class, the commissioner

shall multiply the calculated service payment rate maximum for the A classification by the standard weight for that classification under Minnesota Rules, parts 9549.0050 to 9549.0059, to determine the applicable payment rate maximum. Service payment rate maximums shall be updated annually based on legislatively adopted changes to all service rates for home and community-based service providers.

(g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner may establish alternative payment rate systems for 24-hour customized living services in housing with services establishments which are freestanding buildings with a capacity of 16 or fewer, by applying a single hourly rate for covered component services provided in either:

(1) licensed corporate adult foster homes; or

(2) specialized dementia care units which meet the requirements of section 144D.065 and in which:

(i) each resident is offered the option of having their own apartment; or

(ii) the units are licensed as board and lodge establishments with maximum capacity of eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205, subparts 1, 2, 3, and 4, item A.

(h) 24-hour customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D. All customized living service participants must have a private bedroom unless they choose to share a bedroom with no more than one other family member, except for participants who live in a customized living setting that limits participants to two people per unit. Licensed home care providers are subject to section 256B.0651, subdivision 14.

~~(h)~~ (i) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph (e), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

Sec. 14. Minnesota Statutes 2010, section 256B.092, subdivision 7, is amended to read:

Subd. 7. **Screening teams.** (a) For persons with developmental disabilities, screening teams shall be established which shall evaluate the need for the level of care provided by residential-based habilitation services, residential services, training and habilitation services, and nursing facility services. The evaluation shall address whether home and community-based services are appropriate for persons who are at risk of

placement in an intermediate care facility for persons with developmental disabilities, or for whom there is reasonable indication that they might require this level of care. The screening team shall make an evaluation of need within 60 working days of a request for service by a person with a developmental disability, and within five working days of an emergency admission of a person to an intermediate care facility for persons with developmental disabilities.

(b) The screening team shall consist of the case manager for persons with developmental disabilities, the person, the person's legal guardian or conservator, or the parent if the person is a minor, and a qualified developmental disability professional, as defined in the Code of Federal Regulations, title 42, section 483.430, as amended through June 3, 1988. The case manager may also act as the qualified developmental disability professional if the case manager meets the federal definition.

(c) County social service agencies may contract with a public or private agency or individual who is not a service provider for the person for the public guardianship representation required by the screening or individual service planning process. The contract shall be limited to public guardianship representation for the screening and individual service planning activities. The contract shall require compliance with the commissioner's instructions and may be for paid or voluntary services.

(d) For persons determined to have overriding health care needs and are seeking admission to a nursing facility or an ICF/MR, or seeking access to home and community-based waivered services, a registered nurse must be designated as either the case manager or the qualified developmental disability professional.

(e) For persons under the jurisdiction of a correctional agency, the case manager must consult with the corrections administrator regarding additional health, safety, and supervision needs.

(f) The case manager, with the concurrence of the person, the person's legal guardian or conservator, or the parent if the person is a minor, may invite other individuals to attend meetings of the screening team. With the permission of the person being screened or the person's designated or legal representative, the person's current or proposed provider of services may submit a copy of the provider's assessment or written report outlining their recommendations regarding the person's care needs. The screening team must notify the provider of the date by which this information is to be submitted. This information must be provided to the screening team and must be considered prior to the finalization of the screening.

(g) No member of the screening team shall have any direct or indirect service provider interest in the case.

(h) Nothing in this section shall be construed as requiring the screening team meeting to be separate from the service planning meeting.

Sec. 15. Minnesota Statutes 2011 Supplement, section 256B.49, subdivision 14, is amended to read:

Subd. 14. **Assessment and reassessment.** (a) Assessments of each recipient's strengths, informal support systems, and need for services shall be completed within 20 working days of the recipient's request as provided in section 256B.0911. Reassessment of each recipient's strengths, support systems, and need for services shall be conducted at least every 12 months and at other times when there has been a significant change in the recipient's functioning. With the permission of the recipient or the recipient's designated or legal representative, the recipient's current or proposed provider of services may submit a copy of the provider's assessment or written report outlining their recommendations regarding the recipient's care needs. The person conducting the assessment or reassessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment and must be considered prior to the finalization of the assessment or reassessment.

(b) There must be a determination that the client requires a hospital level of care or a nursing facility level of care as defined in section 256B.0911, subdivision 4a, paragraph (d), at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(c) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only face-to-face assessments conducted according to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care determination or a nursing facility level of care determination must be accepted for purposes of initial and ongoing access to waiver services payment.

(d) Persons with developmental disabilities who apply for services under the nursing facility level waiver programs shall be screened for the appropriate level of care according to section 256B.092.

(e) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.

(f) The commissioner shall develop criteria to identify recipients whose level of functioning is reasonably expected to improve and reassess these recipients to establish a baseline assessment. Recipients who meet these criteria must have a comprehensive

transitional service plan developed under subdivision 15, paragraphs (b) and (c), and be reassessed every six months until there has been no significant change in the recipient's functioning for at least 12 months. After there has been no significant change in the recipient's functioning for at least 12 months, reassessments of the recipient's strengths, informal support systems, and need for services shall be conducted at least every 12 months and at other times when there has been a significant change in the recipient's functioning. Counties, case managers, and service providers are responsible for conducting these reassessments and shall complete the reassessments out of existing funds.

Sec. 16. Minnesota Statutes 2011 Supplement, section 256B.49, subdivision 15, is amended to read:

Subd. 15. **Individualized service plan; comprehensive transitional service plan; maintenance service plan.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written service plan which:

(1) is developed and signed by the recipient within ten working days of the completion of the assessment;

(2) meets the assessed needs of the recipient;

(3) reasonably ensures the health and safety of the recipient;

(4) promotes independence;

(5) allows for services to be provided in the most integrated settings; and

(6) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (p), of service and support providers.

(b) In developing the comprehensive transitional service plan, the individual receiving services, the case manager, and the guardian, if applicable, will identify the transitional service plan fundamental service outcome and anticipated timeline to achieve this outcome. Within the first 20 days following a recipient's request for an assessment or reassessment, the transitional service planning team must be identified. A team leader must be identified who will be responsible for assigning responsibility and communicating with team members to ensure implementation of the transition plan and ongoing assessment and communication process. The team leader should be an individual, such as the case manager or guardian, who has the opportunity to follow the recipient to the next level of service.

Within ten days following an assessment, a comprehensive transitional service plan must be developed incorporating elements of a comprehensive functional assessment and including short-term measurable outcomes and timelines for achievement of and reporting on these outcomes. Functional milestones must also be identified and reported according

to the timelines agreed upon by the transitional service planning team. In addition, the comprehensive transitional service plan must identify additional supports that may assist in the achievement of the fundamental service outcome such as the development of greater natural community support, increased collaboration among agencies, and technological supports.

The timelines for reporting on functional milestones will prompt a reassessment of services provided, the units of services, rates, and appropriate service providers. It is the responsibility of the transitional service planning team leader to review functional milestone reporting to determine if the milestones are consistent with observable skills and that milestone achievement prompts any needed changes to the comprehensive transitional service plan.

For those whose fundamental transitional service outcome involves the need to procure housing, a plan for the recipient to seek the resources necessary to secure the least restrictive housing possible should be incorporated into the plan, including employment and public supports such as housing access and shelter needy funding.

(c) Counties and other agencies responsible for funding community placement and ongoing community supportive services are responsible for the implementation of the comprehensive transitional service plans. Oversight responsibilities include both ensuring effective transitional service delivery and efficient utilization of funding resources.

(d) Following one year of transitional services, the transitional services planning team will make a determination as to whether or not the individual receiving services requires the current level of continuous and consistent support in order to maintain the recipient's current level of functioning. Recipients who are determined to have not had a significant change in functioning for 12 months must move from a transitional to a maintenance service plan. Recipients on a maintenance service plan must be reassessed to determine if the recipient would benefit from a transitional service plan at least every 12 months and at other times when there has been a significant change in the recipient's functioning. This assessment should consider any changes to technological or natural community supports.

(e) When a county is evaluating denials, reductions, or terminations of home and community-based services under section 256B.49 for an individual, the case manager shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the individualized service plan, comprehensive transitional service plan, or maintenance service plan. The reduction in the authorized services for an individual due to changes in funding for waivered services may not exceed

the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

(f) At the time of reassessment, local agency case managers shall assess each recipient of community alternatives for disabled individuals or traumatic brain injury waivered services currently residing in a licensed adult foster home that is not the primary residence of the license holder, or in which the license holder is not the primary caregiver, to determine if that recipient could appropriately be served in a community-living setting. If appropriate for the recipient, the case manager shall offer the recipient, through a person-centered planning process, the option to receive alternative housing and service options. In the event that the recipient chooses to transfer from the adult foster home, the vacated bed shall not be filled with another recipient of waiver services and group residential housing ~~, unless~~ and the licensed capacity shall be reduced accordingly, unless the savings required by the 2011 licensed bed closure reductions for foster care settings where the physical location is not the primary residence of the license holder are met through voluntary changes described in section 245A.03, subdivision 7, paragraph (f), or as provided under section 245A.03, subdivision 7, paragraph (a), clauses (3) and (4)~~, and the licensed capacity shall be reduced accordingly. If the adult foster home becomes no longer viable due to these transfers, the county agency, with the assistance of the department, shall facilitate a consolidation of settings or closure~~. This reassessment process shall be completed by ~~June 30, 2012~~ July 1, 2013.

Sec. 17. **[256B.492] HOME AND COMMUNITY-BASED SETTINGS.**

(a) For purposes of the home and community-based waiver programs under sections 256B.092 and 256B.49, home and community-based settings include:

(1) licensed adult or child foster care settings of four or five, if emergency exception criteria are met; and

(2) other settings that meet the definition of "community-living settings" under section 256B.49, subdivision 23:

(i) in addition to this definition, if a single corporation or entity provides both housing and services, there must be a distinct separation between the housing and services;

(ii) individuals may choose a service provider separate from the housing provider without being required to move; and

(iii) for settings that meet this definition, individuals with disabilities may reside in up to 25 percent of the units unless an exception is granted under paragraph (c).

(b) For purposes of the home and community-based waiver programs under sections 256B.092 and 256B.49, home and community-based settings must not:

(1) be located in a building that is also a publicly or privately operated facility that provides institutional treatment or custodial care;

(2) be located in a building on the grounds of, or immediately adjacent to, a public institution;

(3) be a housing complex designed expressly around an individual's diagnosis or disability;

(4) be segregated based on disability, either physically or because of setting characteristics, from the larger community; or

(5) have the qualities of an institution which include, but are not limited to: regimented meal and sleep times, limitations on visitors, and lack of privacy. Restrictions agreed to and documented in the person's individual service plan shall not result in a residence having the qualities of an institution as long as the restrictions for the person are not imposed upon others in the same residence and are the least restrictive alternative, imposed for the shortest possible time to meet the person's needs.

(c) Upon amendment of the home and community-based services waivers, residential settings which serve persons with disabilities under one of the disability waiver programs in more than 25 percent of the units in a building, but otherwise meet the requirements of this section, may request an exception for the number of units in which services were provided as of January 1, 2012. The commissioner shall grant exception requests which meet the criteria in this section and maintain a list of those settings that have approved exceptions and allow home and community-based waiver payments to be made for services provided.

Sec. 18. Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision 3, is amended to read:

Subd. 3. **Forecasted Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **MFIP/DWP Grants**

	Appropriations by Fund	
General	84,680,000	91,978,000
Federal TANF	84,425,000	75,417,000

(b) **MFIP Child Care Assistance Grants**	55,456,000	30,923,000
(c) **General Assistance Grants**	49,192,000	46,938,000

General Assistance Standard. The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

Emergency General Assistance. The amount appropriated for emergency general assistance funds is limited to no more than $6,689,812 in fiscal year 2012 and $6,729,812 in fiscal year 2013. Funds to counties shall be allocated by the commissioner using the allocation method specified in Minnesota Statutes, section 256D.06.

(d) **Minnesota Supplemental Aid Grants**	38,095,000	39,120,000
(e) **Group Residential Housing Grants**	121,080,000	129,238,000
(f) **MinnesotaCare Grants**	295,046,000	317,272,000

This appropriation is from the health care access fund.

(g) **Medical Assistance Grants**	4,501,582,000	4,437,282,000

Managed Care Incentive Payments. The commissioner shall not make managed care incentive payments for expanding preventive services during fiscal years beginning July 1, 2011, and July 1, 2012.

Reduction of Rates for Congregate Living for Individuals with Lower Needs. Beginning October 1, 2011, through June 30, 2012, lead agencies must reduce rates in effect on January 1, 2011, by ten percent for

individuals with lower needs living in foster care settings where the license holder does not share the residence with recipients on the CADI and DD waivers and customized living settings for CADI. Beginning July 1, 2012, lead agencies must reduce rates in effect on January 1, 2011, by ten percent, for individuals living in foster care settings where the license holder does not share the residence with recipients on the CADI and DD waivers and customized living settings for CADI, in a manner that ensures that: (1) an identical percentage of recipients receiving services under each waiver receive a reduction; and (2) the projected savings for this provision for fiscal year 2013 are achieved, notwithstanding whether or not a recipient is an individual with lower needs. Lead agencies must adjust contracts within 60 days of the effective date.

Reduction of Lead Agency Waiver Allocations to Implement Rate Reductions for Congregate Living for Individuals with Lower Needs. Beginning October 1, 2011, the commissioner shall reduce lead agency waiver allocations to implement the reduction of rates for individuals with lower needs living in foster care settings where the license holder does not share the residence with recipients on the CADI and DD waivers and customized living settings for CADI.

Reduce customized living and 24-hour customized living component rates. Effective July 1, 2011, the commissioner shall reduce elderly waiver customized living and 24-hour customized living component

service spending by five percent through reductions in component rates and service rate limits. The commissioner shall adjust the elderly waiver capitation payment rates for managed care organizations paid under Minnesota Statutes, section 256B.69, subdivisions 6a and 23, to reflect reductions in component spending for customized living services and 24-hour customized living services under Minnesota Statutes, section 256B.0915, subdivisions 3e and 3h, for the contract period beginning January 1, 2012. To implement the reduction specified in this provision, capitation rates paid by the commissioner to managed care organizations under Minnesota Statutes, section 256B.69, shall reflect a ten percent reduction for the specified services for the period January 1, 2012, to June 30, 2012, and a five percent reduction for those services on or after July 1, 2012.

Limit Growth in the Developmental Disability Waiver. The commissioner shall limit growth in the developmental disability waiver to six diversion allocations per month beginning July 1, 2011, through June 30, 2013, and 15 diversion allocations per month beginning July 1, 2013, through June 30, 2015. Waiver allocations shall be targeted to individuals who meet the priorities for accessing waiver services identified in Minnesota Statutes, 256B.092, subdivision 12. The limits do not include conversions from intermediate care facilities for persons with developmental disabilities. Notwithstanding any contrary provisions in

this article, this paragraph expires June 30, 2015.

Limit Growth in the Community Alternatives for Disabled Individuals Waiver. The commissioner shall limit growth in the community alternatives for disabled individuals waiver to 60 allocations per month beginning July 1, 2011, through June 30, 2013, and 85 allocations per month beginning July 1, 2013, through June 30, 2015. Waiver allocations must be targeted to individuals who meet the priorities for accessing waiver services identified in Minnesota Statutes, section 256B.49, subdivision 11a. The limits include conversions and diversions, unless the commissioner has approved a plan to convert funding due to the closure or downsizing of a residential facility or nursing facility to serve directly affected individuals on the community alternatives for disabled individuals waiver. Notwithstanding any contrary provisions in this article, this paragraph expires June 30, 2015.

Personal Care Assistance Relative Care. The commissioner shall adjust the capitation payment rates for managed care organizations paid under Minnesota Statutes, section 256B.69, to reflect the rate reductions for personal care assistance provided by a relative pursuant to Minnesota Statutes, section 256B.0659, subdivision 11.

(h) **Alternative Care Grants** 46,421,000 46,035,000

Alternative Care Transfer. Any money allocated to the alternative care program that

is not spent for the purposes indicated does not cancel but shall be transferred to the medical assistance account.

(i) **Chemical Dependency Entitlement Grants** 94,675,000 93,298,000

Sec. 19. Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision 4, is amended to read:

Subd. 4. **Grant Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **Support Services Grants**

	Appropriations by Fund	
General	8,715,000	8,715,000
Federal TANF	100,525,000	94,611,000

MFIP Consolidated Fund Grants. The TANF fund base is reduced by $10,000,000 each year beginning in fiscal year 2012.

Subsidized Employment Funding Through ARRA. The commissioner is authorized to apply for TANF emergency fund grants for subsidized employment activities. Growth in expenditures for subsidized employment within the supported work program and the MFIP consolidated fund over the amount expended in the calendar year quarters in the TANF emergency fund base year shall be used to leverage the TANF emergency fund grants for subsidized employment and to fund supported work. The commissioner shall develop procedures to maximize reimbursement of these expenditures over the TANF emergency fund base year quarters, and may contract directly with employers

and providers to maximize these TANF emergency fund grants.

(b) **Basic Sliding Fee Child Care Assistance Grants** 37,144,000 38,678,000

Base Adjustment. The general fund base is decreased by $990,000 in fiscal year 2014 and $979,000 in fiscal year 2015.

Child Care and Development Fund Unexpended Balance. In addition to the amount provided in this section, the commissioner shall expend $5,000,000 in fiscal year 2012 from the federal child care and development fund unexpended balance for basic sliding fee child care under Minnesota Statutes, section 119B.03. The commissioner shall ensure that all child care and development funds are expended according to the federal child care and development fund regulations.

(c) **Child Care Development Grants** 774,000 774,000

Base Adjustment. The general fund base is increased by $713,000 in fiscal years 2014 and 2015.

(d) **Child Support Enforcement Grants** 50,000 50,000

Federal Child Support Demonstration Grants. Federal administrative reimbursement resulting from the federal child support grant expenditures authorized under section 1115a of the Social Security Act is appropriated to the commissioner for this activity.

(e) **Children's Services Grants**

	Appropriations by Fund		
General	47,949,000	48,507,000	
Federal TANF	140,000	140,000	

Adoption Assistance and Relative Custody Assistance Transfer. The commissioner may transfer unencumbered appropriation balances for adoption assistance and relative custody assistance between fiscal years and between programs.

Privatized Adoption Grants. Federal reimbursement for privatized adoption grant and foster care recruitment grant expenditures is appropriated to the commissioner for adoption grants and foster care and adoption administrative purposes.

Adoption Assistance Incentive Grants. Federal funds available during fiscal year 2012 and fiscal year 2013 for adoption incentive grants are appropriated to the commissioner for these purposes.

(f) **Children and Community Services Grants** 53,301,000 53,301,000

(g) **Children and Economic Support Grants**

Appropriations by Fund		
General	16,103,000	16,180,000
Federal TANF	700,000	0

Long-Term Homeless Services. $700,000 is appropriated from the federal TANF fund for the biennium beginning July 1, 2011, to the commissioner of human services for long-term homeless services for low-income homeless families under Minnesota Statutes, section 256K.26. This is a onetime appropriation and is not added to the base.

Base Adjustment. The general fund base is increased by $42,000 in fiscal year 2014 and $43,000 in fiscal year 2015.

Minnesota Food Assistance Program. $333,000 in fiscal year 2012 and $408,000 in fiscal year 2013 are to increase the general fund base for the Minnesota food assistance program. Unexpended funds for fiscal year 2012 do not cancel but are available to the commissioner for this purpose in fiscal year 2013.

(h) **Health Care Grants**

Appropriations by Fund		
General	26,000	66,000
Health Care Access	190,000	190,000

Base Adjustment. The general fund base is increased by $24,000 in each of fiscal years 2014 and 2015.

(i) **Aging and Adult Services Grants** 12,154,000 11,456,000

Aging Grants Reduction. Effective July 1, 2011, funding for grants made under Minnesota Statutes, sections 256.9754 and 256B.0917, subdivision 13, is reduced by $3,600,000 for each year of the biennium. These reductions are onetime and do not affect base funding for the 2014-2015 biennium. Grants made during the 2012-2013 biennium under Minnesota Statutes, section 256B.9754, must not be used for new construction or building renovation.

Essential Community Support Grant Delay. Upon federal approval to implement the nursing facility level of care on July 1, 2013, essential community supports

grants under Minnesota Statutes, section 256B.0917, subdivision 14, are reduced by $6,410,000 in fiscal year 2013. Base level funding is increased by $5,541,000 in fiscal year 2014 and $6,410,000 in fiscal year 2015.

Base Level Adjustment. The general fund base is increased by $10,035,000 in fiscal year 2014 and increased by $10,901,000 in fiscal year 2015.

(j) **Deaf and Hard-of-Hearing Grants**	1,936,000	1,767,000
(k) **Disabilities Grants**	15,945,000	18,284,000

Grants for Housing Access Services. In fiscal year 2012, the commissioner shall make available a total of $161,000 in housing access services grants to individuals who relocate from an adult foster care home to a community living setting for assistance with completion of rental applications or lease agreements; assistance with publicly financed housing options; development of household budgets; and assistance with funding affordable furnishings and related household matters.

HIV Grants. The general fund appropriation for the HIV drug and insurance grant program shall be reduced by $2,425,000 in fiscal year 2012 and increased by $2,425,000 in fiscal year 2014. These adjustments are onetime and shall not be applied to the base. Notwithstanding any contrary provision, this provision expires June 30, 2014.

Region 10. Of this appropriation, $100,000 each year is for a grant provided under Minnesota Statutes, section 256B.097.

Base Level Adjustment. The general fund base is increased by $2,944,000 in fiscal year 2014 and $653,000 in fiscal year 2015.

Local Planning Grants for Creating Alternatives to Congregate Living for Individuals with Lower Needs. Of this appropriation, $100,000 in fiscal year 2013 is for administrative functions related to the need determination and planning process required under Minnesota Statutes, sections 144A.351 and 245A.03, subdivision 7, paragraphs (e) and (f). The commissioner shall make available a total of ~~$250,000 per year~~ $400,000 in local and regional planning grants, beginning July 1, ~~2011~~ 2012, to assist lead agencies and provider organizations in developing alternatives to congregate living within the available level of resources for the home and community-based services waivers for persons with disabilities.

Disability Linkage Line. Of this appropriation, $125,000 in fiscal year 2012 and $300,000 in fiscal year 2013 are for assistance to people with disabilities who are considering enrolling in managed care.

(l) **Adult Mental Health Grants**

	Appropriations by Fund	
General	70,570,000	70,570,000
Health Care Access	750,000	750,000
Lottery Prize	1,508,000	1,508,000

Funding Usage. Up to 75 percent of a fiscal year's appropriation for adult mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

Base Adjustment. The general fund base is increased by $200,000 in fiscal years 2014 and 2015.

(m) **Children's Mental Health Grants** 16,457,000 16,457,000

Funding Usage. Up to 75 percent of a fiscal year's appropriation for children's mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

Base Adjustment. The general fund base is increased by $225,000 in fiscal years 2014 and 2015.

(n) **Chemical Dependency Nonentitlement Grants** 1,336,000 1,336,000

Sec. 20. **COMMUNITY FIRST CHOICE OPTION.**

(a) If the final federal regulations under Community First Choice Option are determined by the commissioner, after consultation with interested stakeholders in paragraph (d), to be compatible with Minnesota's fiscal neutrality and policy requirements for redesigning and simplifying the personal care assistance program, assistance at home and in the community provided through the home and community-based services with waivers, state-funded grants, and medical assistance-funded services and programs, the commissioner shall develop and request a state plan amendment to establish services, including self-directed options, under section 1915k of the Social Security Act by January 15, 2013, for implementation on July 1, 2013.

(b) The commissioner shall develop and provide to the chairs of the health and human services policy and finance committees, legislation needed to reform and simplify home care, home and community-based service waivers, and other community support services under the Community First Choice Option by February 15, 2013.

(c) Any savings generated by this option shall accrue to the commissioner for development and implementation of community support services under the Community First Choice Option.

(d) The commissioner shall consult with stakeholders, including persons with disabilities and seniors, who represent a range of disabilities, ages, cultures, and geographic locations, their families and guardians, as well as representatives of advocacy

organizations, lead agencies, direct support staff, labor unions, and a variety of service provider groups.

Sec. 21. **COMMISSIONER AUTHORITY TO REDUCE 2011 CONGREGATE CARE LOW NEED RATE CUT.**

During fiscal years 2013 and 2014, the commissioner shall reduce the 2011 reduction of rates for congregate living for individuals with lower needs to the extent actions taken under Minnesota Statutes, section 245A.03, subdivision 7, paragraph (f), produce savings beyond the amount needed to meet the licensed bed closure savings requirements of Minnesota Statutes, section 245A.03, subdivision 7, paragraph (e). Each February 1, the commissioner shall report to the chairs of the legislative committees with jurisdiction over health and human services finance on any reductions provided under this section. This section is effective on July 1, 2012, and expires on June 30, 2014.

Sec. 22. **HOME AND COMMUNITY-BASED SERVICES WAIVERS AMENDMENT FOR EXCEPTION.**

(a) By September 1, 2012, the commissioner of human services shall submit amendments to the home and community-based waiver plans consistent with the definition of home and community-based settings under Minnesota Statutes, section 256B.492, including a request to allow an exception for those settings that serve persons with disabilities under a home and community-based service waiver in more than 25 percent of the units in a building as of January 1, 2012, but otherwise meet the definition under Minnesota Statutes, section 256B.492.

(b) Notwithstanding paragraph (a), a program in Hennepin County established as part of a Hennepin County demonstration project by January 1, 2013, is qualified for the exception allowed under paragraph (a).

Sec. 23. **REPEALER.**

Minnesota Statutes 2011 Supplement, section 256B.5012, subdivision 13, and Laws 2011, First Special Session chapter 9, article 7, section 54, are repealed.

ARTICLE 5

MISCELLANEOUS

Section 1. Minnesota Statutes 2010, section 254A.19, is amended by adding a subdivision to read:

Subd. 4. **Civil commitments.** A Rule 25 assessment, under Minnesota Rules, part 9530.6615, does not need to be completed for an individual being committed as a chemically dependent person, as defined in section 253B.02, and for the duration of a civil commitment under section 253B.065, 253B.09, or 253B.095 in order for a county to access consolidated chemical dependency treatment funds under section 254B.04. The county must determine if the individual meets the financial eligibility requirements for the consolidated chemical dependency treatment funds under section 254B.04. Nothing in this subdivision shall prohibit placement in a treatment facility or treatment program governed under this chapter or Minnesota Rules, parts 9530.6600 to 9530.6655.

Sec. 2. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision to read:

Subd. 18d. **Drug convictions.** (a) The state court administrator shall report every six months by electronic means to the commissioner of human services the name, address, date of birth, and, if available, driver's license or state identification card number, date of sentence, effective date of the sentence, and county in which the conviction occurred of each individual who has been convicted of a felony under chapter 152 during the previous six months.

(b) The commissioner shall determine whether the individuals who are the subject of the data reported under paragraph (a) are receiving public assistance under chapter 256D or 256J, and if any individual is receiving assistance under chapter 256D or 256J, the commissioner shall instruct the county to proceed under section 256D or 256J.26, whichever is applicable, for this individual.

(c) The commissioner shall not retain any data received under paragraph (a) that does not relate to an individual receiving publicly funded assistance under chapter 256J or 256D.

(d) In addition to the routine data transfer under paragraph (a), the state court administrator shall provide a onetime report of the data fields under paragraph (a) for individuals with a felony drug conviction under chapter 152 dated from July 1, 1997, until the date of the data transfer. The commissioner shall perform the tasks identified under paragraph (b) related to this data and shall retain the data according to paragraph (c).

EFFECTIVE DATE. This section is effective January 1, 2013.

Sec. 3. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision to read:

Subd. 18e. **Data sharing with the Department of Human Services; multiple identification cards.** (a) The commissioner of public safety shall, on a monthly basis, provide the commissioner of human services with the first, middle, and last name, the address, date of birth, and driver's license or state identification card number of all applicants and holders whose drivers' licenses and state identification cards have been canceled under section 171.14, paragraph (a), clauses (2) or (3), by the commissioner of public safety. After the initial data report has been provided by the commissioner of public safety to the commissioner of human services under this paragraph, subsequent reports shall only include cancellations that occurred after the end date of the cancellations represented in the previous data report.

(b) The commissioner of human services shall compare the information provided under paragraph (a) with the commissioner's data regarding recipients of all public assistance programs managed by the Department of Human Services to determine whether any individual with multiple identification cards issued by the Department of Public Safety has illegally or improperly enrolled in any public assistance program managed by the Department of Human Services.

(c) If the commissioner of human services determines that an applicant or recipient has illegally or improperly enrolled in any public assistance program, the commissioner shall provide all due process protections to the individual before terminating the individual from the program according to applicable statute and notifying the county attorney.

EFFECTIVE DATE. This section is effective January 1, 2013.

Sec. 4. Minnesota Statutes 2010, section 256.01, is amended by adding a subdivision to read:

Subd. 18f. **Data sharing with the Department of Human Services; legal presence status.** (a) The commissioner of public safety shall, on a monthly basis, provide the commissioner of human services with the first, middle, and last name, address, date of birth, and driver's license or state identification number of all applicants and holders of drivers' licenses and state identification cards whose temporary legal presence status has expired and whose driver's license or identification card has been canceled under section 171.14 by the commissioner of public safety.

(b) The commissioner of human services shall use the information provided under paragraph (a) to determine whether the eligibility of any recipients of public assistance programs managed by the Department of Human Services has changed as a result of the status change in the Department of Public Safety data.

(c) If the commissioner of human services determines that a recipient has illegally or improperly received benefits from any public assistance program, the commissioner shall provide all due process protections to the individual before terminating the individual from the program according to applicable statute and notifying the county attorney.

EFFECTIVE DATE. This section is effective January 1, 2013.

Sec. 5. Minnesota Statutes 2010, section 256B.0943, subdivision 9, is amended to read:

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) each individual provider's caseload size permits the provider to deliver services to both clients with severe, complex needs and clients with less intensive needs. The provider's caseload size should reasonably enable the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

(2) site-based programs, including day treatment and preschool programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan;

(3) a day treatment program is provided to a group of clients by a multidisciplinary team under the clinical supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that is ~~under contract with the county board~~ certified under subdivision 4 to operate a program that meets the requirements of ~~section 245.4712, subdivision 2, or 245.4884, subdivision 2, and~~ Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The program must be available at least one day a week for a two-hour time block. The two-hour time block must include at least one hour of individual or group psychotherapy. The remainder of the structured treatment program may include individual or group psychotherapy, and individual or group skills training, if included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services. A day treatment program may provide fewer than the minimally required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program; and

(4) a therapeutic preschool program is a structured treatment program offered to a child who is at least 33 months old, but who has not yet reached the first day of kindergarten, by a preschool multidisciplinary team in a day program licensed under Minnesota Rules, parts 9503.0005 to 9503.0175. The program must be available two hours per day, five days per week, and 12 months of each calendar year. The structured treatment program may include individual or group psychotherapy and individual or group skills training, if included in the client's individual treatment plan. A therapeutic preschool program may provide fewer than the minimally required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program.

(b) A provider entity must deliver the service components of children's therapeutic services and supports in compliance with the following requirements:

(1) individual, family, and group psychotherapy must be delivered as specified in Minnesota Rules, part 9505.0323;

(2) individual, family, or group skills training must be provided by a mental health professional or a mental health practitioner who has a consulting relationship with a mental health professional who accepts full professional responsibility for the training;

(3) crisis assistance must be time-limited and designed to resolve or stabilize crisis through arrangements for direct intervention and support services to the child and the child's family. Crisis assistance must utilize resources designed to address abrupt or substantial changes in the functioning of the child or the child's family as evidenced by a sudden change in behavior with negative consequences for well being, a loss of usual coping mechanisms, or the presentation of danger to self or others;

(4) mental health behavioral aide services must be medically necessary treatment services, identified in the child's individual treatment plan and individual behavior plan, which are performed minimally by a paraprofessional qualified according to subdivision 7, paragraph (b), clause (3), and which are designed to improve the functioning of the child in the progressive use of developmentally appropriate psychosocial skills. Activities involve working directly with the child, child-peer groupings, or child-family groupings to practice, repeat, reintroduce, and master the skills defined in subdivision 1, paragraph (p), as previously taught by a mental health professional or mental health practitioner including:

(i) providing cues or prompts in skill-building peer-to-peer or parent-child interactions so that the child progressively recognizes and responds to the cues independently;

(ii) performing as a practice partner or role-play partner;

(iii) reinforcing the child's accomplishments;

(iv) generalizing skill-building activities in the child's multiple natural settings;

(v) assigning further practice activities; and

(vi) intervening as necessary to redirect the child's target behavior and to de-escalate behavior that puts the child or other person at risk of injury.

A mental health behavioral aide must document the delivery of services in written progress notes. The mental health behavioral aide must implement treatment strategies in the individual treatment plan and the individual behavior plan. The mental health behavioral aide must document the delivery of services in written progress notes. Progress notes must reflect implementation of the treatment strategies, as performed by the mental health behavioral aide and the child's responses to the treatment strategies; and

(5) direction of a mental health behavioral aide must include the following:

(i) a clinical supervision plan approved by the responsible mental health professional;

(ii) ongoing on-site observation by a mental health professional or mental health practitioner for at least a total of one hour during every 40 hours of service provided to a child; and

(iii) immediate accessibility of the mental health professional or mental health practitioner to the mental health behavioral aide during service provision.

Sec. 6. Minnesota Statutes 2010, section 518A.40, subdivision 4, is amended to read:

Subd. 4. **Change in child care.** (a) When a court order provides for child care expenses, and child care support is not assigned under section 256.741, the public authority, if the public authority provides child support enforcement services, ~~must~~ may suspend collecting the amount allocated for child care expenses when~~:~~

~~(1)~~ either party informs the public authority that no child care costs are being incurred~~;~~ and:

~~(2)~~ (1) the public authority verifies the accuracy of the information with the obligee~~.~~; or

(2) the obligee fails to respond within 30 days of the date of a written request from the public authority for information regarding child care costs. A written or oral response from the obligee that child care costs are being incurred is sufficient for the public authority to continue collecting child care expenses.

The suspension is effective as of the first day of the month following the date that the public authority ~~received the verification~~ either verified the information with the obligee or the obligee failed to respond. The public authority will resume collecting child care expenses when either party provides information that child care costs ~~have resumed~~ are incurred, or when a child care support assignment takes effect under section 256.741,

subdivision 4. The resumption is effective as of the first day of the month after the date that the public authority received the information.

(b) If the parties provide conflicting information to the public authority regarding whether child care expenses are being incurred, ~~or if the public authority is unable to verify with the obligee that no child care costs are being incurred,~~ the public authority will continue or resume collecting child care expenses. Either party, by motion to the court, may challenge the suspension, continuation, or resumption of the collection of child care expenses under this subdivision. If the public authority suspends collection activities for the amount allocated for child care expenses, all other provisions of the court order remain in effect.

(c) In cases where there is a substantial increase or decrease in child care expenses, the parties may modify the order under section 518A.39.

Sec. 7. Laws 2011, First Special Session chapter 9, article 9, section 18, is amended to read:

Sec. 18. **WHITE EARTH BAND OF OJIBWE HUMAN SERVICES PROJECT.**

(a) The commissioner of human services, in consultation with the White Earth Band of Ojibwe, shall transfer legal responsibility to the tribe for providing human services to tribal members and their families who reside on or off the reservation in Mahnomen County. The transfer shall include:

(1) financing, including federal and state funds, grants, and foundation funds; and

(2) services to eligible tribal members and families defined as it applies to state programs being transferred to the tribe.

(b) The determination as to which programs will be transferred to the tribe and the timing of the transfer of the programs shall be made by a consensus decision of the governing body of the tribe and the commissioner. The commissioner shall waive existing rules and seek all federal approvals and waivers as needed to carry out the transfer.

(c) When the commissioner approves transfer of programs and the tribe assumes responsibility under this section, Mahnomen County is relieved of responsibility for providing program services to tribal members and their families who live on or off the reservation while the tribal project is in effect and funded, except that a family member who is not a White Earth member may choose to receive services through the tribe or the county. The commissioner shall have authority to redirect funds provided to Mahnomen County for these services, including administrative expenses, to the White Earth Band of Ojibwe Indians.

(d) Upon the successful transfer of legal responsibility for providing human services for tribal members and their families who reside on and off the reservation in Mahnomen County, the commissioner and the White Earth Band of Ojibwe shall develop a plan to transfer legal responsibility for providing human services for tribal members and their families who reside on or off reservation in Clearwater and Becker Counties.

(e) No later than January 15, 2012, the commissioner shall submit a written report detailing the transfer progress to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services. If legislation is needed to fully complete the transfer of legal responsibility for providing human services, the commissioner shall submit proposed legislation along with the written report.

(f) Upon receipt of 100 percent match for health care costs from the Indian Health Service, the first $500,000 of savings to the state in tribal health care costs shall be distributed to the White Earth Band of Ojibwe to offset the band's cost of implementing the human services project. The remainder of the state savings shall be distributed to the White Earth Band of Ojibwe to supplement services to off-reservation tribal members.

Sec. 8. **FOSTER CARE FOR INDIVIDUALS WITH AUTISM.**

The commissioner of human services shall identify and coordinate with one or more counties that agree to issue a foster care license and authorize funding for people with autism who are currently receiving home and community-based services under Minnesota Statutes, section 256B.092 or 256B.49. Children eligible under this section must be in an out-of-home placement approved by the lead agency that has legal responsibility for the placement. Nothing in this section must be construed as restricting an individual's choice of provider. The commissioner will assist the interested county or counties with obtaining necessary capacity within the moratorium under Minnesota Statutes, section 245A.03, subdivision 7. The commissioner shall coordinate with the interested counties and issue a request for information to identify providers who have the training and skills to meet the needs of the individuals identified in this section.

Sec. 9. **DIRECTION TO COMMISSIONER.**

The commissioner shall develop an optional certification for providers of home and community-based services waivers under Minnesota Statutes, sections 256B.092 or 256B.49, that demonstrates competency in working with individuals with autism. Recommended language and an implementation plan will be provided to the chairs and ranking minority members of the legislative committees with jurisdiction over health and

human services policy and finance by February 15, 2013, as part of the Quality Outcome Standards required under Laws 2010, chapter 352, article 1, section 24.

Sec. 10. **CHEMICAL HEALTH NAVIGATOR PROGRAM.**

(a) The commissioner of human services, in partnership with the counties, tribes, and stakeholders, shall develop a community based integrated model of care to improve the effectiveness and efficiency of the service continuum for chemically dependent individuals. The plan shall identify methods to reduce duplication of efforts, promote scientifically supported practices, and improve efficiency. This plan shall consider the potential for geographically or demographically disparate impact on individuals who need chemical dependency services.

(b) The commissioner shall provide the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services a report detailing necessary statutory and rule changes and a proposed pilot project to implement the plan no later than March 15, 2013.

Sec. 11. **DIRECTIONS TO THE COMMISSIONER.**

The commissioner of human services, in consultation with the commissioner of public safety, shall report to the legislative committees with jurisdiction over health and human services policy and finance regarding the implementations of Minnesota Statutes, section 256.01, subdivisions 18d, 18e, and 18f, and the number of persons affected and fiscal impact by program by April 1, 2013.

Sec. 12. **MINNESOTA SPECIALTY HEALTH SERVICES; WILLMAR.**

The commissioner of human services shall manage and restructure department resources to achieve savings in order to continue operations of the Minnesota Health Services, Willmar site, until July 1, 2013.

ARTICLE 6

HEALTH AND HUMAN SERVICES APPROPRIATIONS

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

	2012	**2013**	**Total**
General	$ 5,000	$ (5,000)	$ -0-

Federal TANF		-0-	1,533,000	1,533,000
Total	**$**	**5,000**	**$ 1,528,000**	**$ 1,533,000**

Sec. 2. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2011, First Special Session chapter 9, article 10, to the agencies and for the purposes specified in this article. The appropriations are from the general fund or other named fund and are available for the fiscal years indicated for each purpose. The figures "2012" and "2013" used in this article mean that the addition to or subtraction from the appropriation listed under them is available for the fiscal year ending June 30, 2012, or June 30, 2013, respectively. Supplemental appropriations and reductions to appropriations for the fiscal year ending June 30, 2012, are effective the day following final enactment unless a different effective date is explicit.

	APPROPRIATIONS Available for the Year Ending June 30	
	2012	**2013**

Sec. 3. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation**	**$**	**5,000**	**$ 1,205,000**

Appropriations by Fund

	2012	2013
General	5,000	(328,000)
Federal TANF	-0-	1,533,000

Subd. 2. **Central Office Operations**

Appropriations by Fund

General	4,000	137,000

Return On Taxpayer Investment Implementation Study. $100,000 is appropriated in fiscal year 2013 from the general fund to the commissioner of human services for a grant to the commissioner of management and budget to develop recommendations for implementing a return on taxpayer investment (ROTI)

methodology and practice related to human services and corrections programs administered and funded by state and county government. The scope of the study shall include assessments of ROTI initiatives in other states, design implications for Minnesota, and identification of one or more Minnesota institutions of higher education capable of providing rigorous and consistent nonpartisan institutional support for ROTI. The commissioner shall consult with representatives of other state agencies, counties, legislative staff, Minnesota institutions of higher education, and other stakeholders in developing recommendations. The commissioner shall report findings and recommendations to the governor and legislature by November 30, 2012. This appropriation is added to the base.

PRISM. In fiscal year 2012, $4,000 is for programming costs related to child support enforcement. This appropriation is onetime.

Subd. 3. **Forecasted Programs**

	Appropriations by Fund			
General	1,000	1,832,000		
Federal TANF	-0-	243,000		
(a) **Group Residential Housing Grants**			-0-	1,115,000

Managing Residential Settings. If the commissioner's efforts to implement Minnesota Statutes, section 256B.492 results in general fund savings as compared to base level costs in the February 2012 Department of Management and Budget forecast of revenues and expenditures, the savings shall be applied to reduce the reductions

to congregate care rates for low needs individuals specified in Laws 2011, First Special Session chapter 9, effective July 1, 2013.

Teen Challenge. $1,103,000 is appropriated in fiscal year 2014 from the general fund to the commissioner for the purpose of providing a group residential housing supplementary service rate to a provider under Minnesota Statutes, section 256I.05, subdivision 1e. This appropriation is added to the base.

(b) **Medical Assistance Grants** 1,000 (1,740,000)

PCA Relative Care Payment Recovery. Notwithstanding any law to the contrary, and if, at the conclusion of the HealthStar Home Health, Inc et al v. Commissioner of Human Services litigation, the PCA relative rate reduction under Minnesota Statutes, section 256B.0659, subdivision 11, paragraph (c), is upheld, the commissioner is prohibited from recovering the difference between the 100 percent rate paid to providers and the 80 percent rate, during the period of the temporary injunction issued on October 26, 2011. This section does not prohibit the commissioner from recovering any other overpayments from providers.

Managing Corporate Foster Care. The commissioner of human services shall manage foster care beds under Minnesota Statutes, section 245A.03, subdivision 7, in order to reduce costs by $3,907,000 in fiscal year 2013 as compared to base level costs in the February 2012 Department of

Management and Budget forecast of revenues and expenditures. If the department's efforts to implement this provision results in savings greater than $3,907,000 in fiscal year 2014, the additional savings shall be applied to reduce the reductions to congregate care rates for low needs individuals specified in Laws 2011, First Special Session chapter 9, effective July 1, 2013.

Elderly Waiver Critical Access. $150,000 is appropriated from the general fund in fiscal year 2013 to the commissioner of human services for purposes of implementing the requirements of Minnesota Statutes, section 256B.0915, subdivision 3g, paragraph (d). This is a onetime appropriation and is available until expended.

Nursing Facility Moratorium Exceptions. For fiscal year 2014, $1,500,000 is for rate increases approved through the nursing facility moratorium exception process.

Continuing Care Provider Payment Delay. If the commissioner of human services does not receive the federal waiver requested under Laws 2011, First Special Session chapter 9, article 7, section 52, by July 1, 2012, the commissioner shall delay the last payment or payments in fiscal year 2013 to providers listed in Minnesota Statutes 2011 supplement, section 256B.5012, subdivision 13, and Laws 2011, First Special Session chapter 9, article 7, section 54, as they existed before the repeal in this act, by up to $22,854,000 in state match, reduced by any cash basis state share savings from

implementing the level of care waiver before July 1, 2013, and make these payments in July 2013. If the commissioner of human services receives the federal waiver requested under Laws 2011, First Special Session chapter 9, article 7, section 52, between July 1, 2012, and June 30, 2013, payments to the providers listed under Minnesota Statutes 2011 Supplement, section 256B.5012, subdivision 13, and Laws 2011, First Special Session chapter 9, article 7, section 54, as they existed before being repealed in this act, in June 2013 shall be reduced by up to $22,854,000 in state match, as necessary to match the amount of the reduction that would have happened up to the date the waiver is received and the resulting amount must be paid to the providers in July 2013.

Contingent Managed Care Provider Payment Increases. Any money received by the state as a result of the cap on earnings in the 2011 contract or 2011 contract amendments for services provided under Minnesota Statutes, sections 256B.69 and 256L.12, shall be used to retroactively increase medical assistance and MinnesotaCare capitation payments to managed care plans for calendar year 2011. The commissioner of human services shall require managed care plans to use the entire amount of any increase in capitation rates provided under this provision to retroactively increase calendar year 2011 payment rates for health care providers employed by or under contract with the plan, including nursing facilities that provide services to emergency

medical assistance recipients, but excluding payments to hospitals and other institutional providers for facility, administrative, and other operating costs not related to direct patient care. Increased payments must be distributed in proportion to each provider's share of total plan payments received for services provided to medical assistance and MinnesotaCare enrollees. Any increase in provider payment rates under this provision is onetime and shall not increase base provider payment rates.

(c) **MFIP Child Care Assistance Grants**

$371,000 is appropriated in fiscal year 2013 from the TANF fund for the purposes of the absent day policy under Minnesota Statutes, section 119B.13, subdivision 7. $236,000 in fiscal year 2013 from the TANF fund for a one percent increase in accreditation differential. This appropriation is ongoing.

Subd. 4. **Grant Programs**

	Appropriations by Fund	
General	-0-	160,000
Federal TANF	-0-	1,290,000

(a) **Support Services Grants** -0- 1,000,000

Healthy Community Initiatives. $300,000 in fiscal year 2013 is appropriated from the TANF fund to the commissioner of human services for contracting with the Search Institute to promote healthy community initiatives. The commissioner may expend up to five percent of the appropriation to provide for the program evaluation. This appropriation must be used to serve families with incomes below 200 percent

of the federal poverty guidelines and minor children in the household. This is a onetime appropriation and is available until expended.

Circles of Support. $400,000 in fiscal year 2013 are appropriated from the TANF fund to the commissioner of human services for the purpose of providing grants to three community action agencies for circles of support initiatives. This appropriation must be used to serve families with incomes below 200 percent of the federal poverty guidelines and minor children in the household. This is a onetime appropriation and is available until expended.

Northern Connections. $300,000 is appropriated from the TANF fund in fiscal year 2013 to the commissioner of human services for a grant to Northern Connections in Perham for a workforce program that provides one-stop supportive services to individuals as they transition into the workforce. This appropriation must be used for families with incomes below 200 percent of the federal poverty guidelines and with minor children in the household. This is a onetime appropriation and is available until expended.

Transitional Housing Services. $..... is appropriated in fiscal year ..... to the commissioner of human services from the TANF fund for transitional housing services, including the provision of up to four months of rental assistance under Minnesota Statutes, section 256E.33. This appropriation must be used for homeless families with children with

incomes below 115 percent of the federal poverty guidelines, and must be coordinated with family stabilization services under Minnesota Statutes, section 256J.575.

(b) **Children and Economic Support Grants** -0- 100,000

(c) **Basic Sliding Fee Child Care Grants**

Basic Sliding Fee. $292,000 is appropriated from the TANF fund in fiscal year 2013 to the commissioner for the purposes of the absent day policy under Minnesota Statutes, section 119B.13, subdivision 7. $148,000 in fiscal year 2013 from the TANF fund for a one percent increase in accreditation differential. This appropriation is added to the base.

(d) **Disabilities Grants** -0- 160,000

Living Skills Training for Persons with Intractable Epilepsy. $65,000 is appropriated in fiscal year 2013 from the general fund to the commissioner of human services for living skills training programs for persons with intractable epilepsy who need assistance in the transition to independent living under Laws 1988, chapter 689. This is a onetime appropriation and is available until expended.

Self-advocacy Network for Persons with Disabilities.

(1) $95,000 is appropriated from the general fund in fiscal year 2013 to the commissioner of human services to establish and maintain a statewide self-advocacy network for persons with intellectual and developmental disabilities. This is a onetime appropriation and is available until expended.

(2) The self-advocacy network must focus on ensuring that persons with disabilities are:

(i) informed of and educated about their legal rights in the areas of education, employment, housing, transportation, and voting; and

(ii) educated and trained to self-advocate for their rights under law.

(3) Self-advocacy network activities under this section include but are not limited to:

(i) education and training, including preemployment and workplace skills;

(ii) establishment and maintenance of a communication and information exchange system for self-advocacy groups; and

(iii) financial and technical assistance to self-advocacy groups.

Sec. 4. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$ -0- $ 323,000**

Appropriations by Fund

	2012	2013
General	-0-	323,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Policy Quality and Compliance**

Appropriations by Fund

General	-0-	223,000

Web site Changes. $36,000 from the general fund is for Web site changes required in article 2, section 7. This is a onetime

appropriation and must be shared with the Department of Human Services through an interagency agreement.

Management and Budget. $100,000 from the general fund is for the commissioner to transfer to the commissioner of management and budget for the evaluation and report required in article 2, section 7. This is a onetime appropriation.

For-Profit HMO Study. $79,000 is for a study of for-profit health maintenance organizations. This is onetime and available until expended.

Nursing Facility Moratorium Exceptions.

(a) Beginning in fiscal year 2013, the commissioner of health may approve moratorium exception projects under Minnesota Statutes, section 144A.073, for which the full annualized state share of medical assistance costs does not exceed $1,500,000.

(b) In fiscal year 2013, $8,000 is for administrative costs related to review of moratorium exception projects.

Subd. 3. **Health Protection.**

	Appropriations by Fund	
General	-0-	100,000

Aliveness Project. $100,000 in fiscal year 2013 is for a grant to the Aliveness Project, a statewide nonprofit, for providing the health and wellness services it has provided to individuals throughout Minnesota since its inception in 1985. The activities and proposed outcomes supported by this

onetime appropriation must further the comprehensive plan of the Department of Health, HIV/AIDS program. This is a onetime appropriation and is available until expended.

Autism Study. $200,000 is for the commissioner of health, in partnership with the University of Minnesota, to conduct a qualitative study focused on cultural and resource-based aspects of autism spectrum disorders (ASD) that are unique to the Somali community. By February 15, 2013, the commissioner shall report the findings of this study to the legislature. The report must include recommendations as to establishment of a population-based public health surveillance system for ASD.

Sec. 5. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2013, unless a different expiration date is explicit.

Sec. 6. **EFFECTIVE DATE.**

The provisions in this article are effective July 1, 2012, unless a different effective date is explicit."

Amend the title accordingly