..... moves to amend H.F. No. 2294, the delete everything amendment (H2294DE2), as follows:

Page 4, after line 31, insert:

"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."

Page 6, line 7, delete everything after the period

Page 6, delete line 8

Page 7, after line 16, insert:

"Sec. 10. 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. 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."

Page 7, after line 32, insert:

"Sec. 11. **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. 12. **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."

Page 12, delete section 1 and insert:

"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."

Page 23, line 25, delete "church" and insert "faith-based"

Page 23, line 26, delete "2014" and insert "2013"

Page 24, line 28, before the period, insert "using the resource need determination process described in paragraph (f)"

Page 24, line 30, after the comma, insert "and other data and information, including"

Page 24, line 32, delete "as a component of"

Page 25, line 31, delete "statewide"

Page 25, line 32, delete the new language and insert "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"

Page 25, line 33, delete everything before the period

Page 26, line 2, delete "will" and insert "and other data and information shall be used to"

Page 26, after line 13, insert:

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

Page 33, delete lines 34 and 35

Page 34, delete lines 1 to 10 and insert:

"(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."

Page 34, after line 13, insert:

"Sec. 6. 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."

Page 47, delete section 16

Page 47, lines 13 and 14, reinstate the stricken language

Page 47, line 15, reinstate the stricken "residential housing" and insert "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" and reinstate everything after the stricken "unless"

Page 47, line 16, reinstate the stricken "clauses (3) and (4)" and insert a period

Page 47, line 25, delete "For settings created after July 1, 2013,"

Page 48, line 3, delete "transitioning"

Page 48, line 4, delete "out of foster care settings" and before the period insert " unless an exception is granted under paragraph (c)"

Page 48, delete lines 21 to 23, and insert:

"(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."

Page 48, after line 23, insert:

"Sec. ... 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. .... 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"

Page 49, delete sections 19 and 20

Page 50, delete section 21

Page 50, after line 11, insert:

"Sec. .... **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. .... **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)."

Page 52, after line 23, insert:

"Sec. .... 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."

Page 58, after line 22, insert:

"**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."

Page 59, line 16, after the period, insert "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. "

Page 59, line 27, after "$22,854,000" insert "in state match"

Page 60, line 14, after the comma, insert "including nursing facilities that provide services to emergency medical assistance recipients,"

Page 60, line 30, after the period, insert "$236,000 in fiscal year 2013 from the TANF fund for a one percent increase in accreditation differential."

Page 62, after line 3 insert

"**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."

Page 62, delete line 5, and insert: "**Community Action Agencies.** $250,000"

Page 62, line 7, delete everything after "fund"

Page 62, delete line 8

Page 62, line 9, delete everything before "under" and insert "for grants to community action agencies"

Page 62, line 10, delete "256E.35" and insert "256E.30"

Page 62, line 22, after the period, insert "$148,000 in fiscal year 2013 from the TANF fund for a one percent increase in accreditation differential"

Page 64, after line 21, insert:

"**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."

Amend the totals and summaries by fund accordingly

Renumber the sections in sequence and correct the internal references

Amend the title accordingly