State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-SEVENTH SESSION

H. F. No. 2901

03/15/2012 Authored by Huntley; Murphy, E.; Loeffler; Hosch and Liebling
The bill was read for the first time and referred to the Committee on Health and Human Services Finance

A bill for an act

relating to state government; making adjustments to health and human services appropriations; making changes to health care and continuing care; modifying program eligibility requirements; making changes to human services licensing and provider screening; establishing fees and modifying fee schedules; appropriating money; amending Minnesota Statutes 2010, section 256B.056, subdivision 1a; Minnesota Statutes 2011 Supplement, sections 245A.03, subdivision 7; 245A.10, subdivisions 3, 4; 256B.056, subdivision 3; 256B.057, subdivision 9; 256B.06, subdivision 4; 256B.0659, subdivisions 11, 28; 256B.49, subdivision 15; 256B.69, subdivision 5c; Laws 2011, First Special Session chapter 9, article 7, sections 52; 54; article 10, section 3, subdivision 3.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1

HUMAN SERVICES

Section 1. 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. 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.

(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 statewide licensed capacity for ~~the home~~ foster care settings where the physical location is not the primary residence of the license holder. A decreased licensed capacity according to this paragraph is not subject to appeal under this chapter. A needs determination process, managed at the state level, with county input, will determine where the reduced capacity will occur.

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

Sec. 2. Minnesota Statutes 2011 Supplement, section 245A.10, subdivision 3, is amended to read:

Subd. 3. **Application fee for initial license or certification.** (a) For fees required under subdivision 1, an applicant for an initial license or certification issued by the commissioner shall submit a $500 application fee with each new application required under this subdivision. The application fee shall not be prorated, is nonrefundable, and is in lieu of the annual license or certification fee that expires on December 31. The commissioner shall not process an application until the application fee is paid.

(b) Except as provided in clauses (1) to (4), an applicant shall apply for a license to provide services at a specific location.

(1) For a license to provide residential-based habilitation services to persons with developmental disabilities under chapter 245B, an applicant shall submit an application for each county in which the services will be provided. Upon licensure, the license holder may provide services to persons in that county plus no more than three persons at any one time in each of up to ten additional counties. A license holder in one county

may not provide services ~~under the home and community-based waiver~~ for persons with developmental disabilities to more than three people in a second county without holding a separate license for that second county. Applicants or licensees providing services under this clause to not more than three persons remain subject to the inspection fees established in section 245A.10, subdivision 2, for each location. The license issued by the commissioner must state the name of each additional county where services are being provided to persons with developmental disabilities. A license holder must notify the commissioner before making any changes that would alter the license information listed under section 245A.04, subdivision 7, paragraph (a), including any additional counties where persons with developmental disabilities are being served.

(2) For a license to provide supported employment, crisis respite, or semi-independent living services to persons with developmental disabilities under chapter 245B, an applicant shall submit a single application to provide services statewide.

(3) For a license to provide independent living assistance for youth under section 245A.22, an applicant shall submit a single application to provide services statewide.

(4) For a license for a private agency to provide foster care or adoption services under Minnesota Rules, parts 9545.0755 to 9545.0845, an applicant shall submit a single application to provide services statewide.

(c) Notwithstanding paragraphs (a) and (b), an applicant for an initial license issued by the commissioner to provide home and community-based services to persons with disabilities or persons age 65 and older under chapter 245D must submit a $585 application fee with each new application as follows:

(1) a single application for a license to provide one or more of the following services: housing access coordination; behavioral programming; specialist services; companion services; personal support; 24-hour emergency assistance, on-call and personal emergency response; night supervision; homemaker services, excluding providers licensed by the Department of Health under chapter 144A or those providers providing cleaning services only; respite; or independent living skills training;

(2) a single application for a license to provide structured day or prevocational services; or

(3) a single application for a license to provide supported employment.

(d) The initial application fee charged under this subdivision does not include the temporary license surcharge under section 16E.22.

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

Sec. 3. Minnesota Statutes 2011 Supplement, section 245A.10, subdivision 4, is amended to read:

Subd. 4. **License or certification fee for certain programs.** (a) Child care centers shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	Child Care Center License Fee
1 to 24 persons	$200
25 to 49 persons	$300
50 to 74 persons	$400
75 to 99 persons	$500
100 to 124 persons	$600
125 to 149 persons	$700
150 to 174 persons	$800
175 to 199 persons	$900
200 to 224 persons	$1,000
225 or more persons	$1,100

(b) A program licensed to provide day training and habilitation ~~program serving~~ services to persons with developmental disabilities under chapter 245B or ~~related conditions~~ structured day or prevocational services to persons with disabilities under chapter 245D, shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$800
25 to 49 persons	$1,000
50 to 74 persons	$1,200
75 to 99 persons	$1,400
100 to 124 persons	$1,600
125 to 149 persons	$1,800
150 or more persons	$2,000

(1) Except as provided in ~~paragraph (c)~~ clause (2), when a ~~day training and habilitation~~ program serves more than 50 percent of the same persons in two or more locations in a community, the ~~day training and habilitation~~ program shall pay a license fee based on the licensed capacity of the largest facility and the other facility or facilities shall be charged ~~a~~ an annual, nonrefundable license fee based on a licensed capacity of a ~~residential~~ program serving one to 24 persons.

~~(c) When~~ (2) A day training and habilitation program ~~serving persons~~ with ~~developmental disabilities or related conditions seeks~~ a single license allowed under section 245B.07, subdivision 12, clause (2) or (3), ~~the~~ must be charged an annual,

nonrefundable licensing fee ~~must be~~ based on the combined licensed capacity for each location.

(3) A program providing services in community-based settings only and not in a licensed facility, must pay an annual, nonrefundable license fee based on a licensed capacity of one to 24 persons.

(4) A program licensed to provide day training and habilitation services to persons with developmental disabilities under chapter 245B and structured day or prevocational services to persons with disabilities under chapter 245D must pay a single annual, nonrefundable license fee based on the combined license capacity of all services.

~~(d)~~ (c) A program licensed to provide supported employment services to persons with developmental disabilities under chapter 245B or to persons with disabilities under chapter 245D shall pay an annual nonrefundable license fee of $650.

~~(c)~~ (d) A program licensed to provide crisis respite services to persons with developmental disabilities under chapter 245B shall pay an annual nonrefundable license fee of $700.

~~(f)~~ (e) A program licensed to provide semi-independent living services to persons with developmental disabilities under chapter 245B shall pay an annual nonrefundable license fee of $700.

~~(g)~~ (f) A program licensed to provide residential-based habilitation services under the home and community-based waiver for persons with developmental disabilities shall pay an annual license fee that includes a base rate of $690 plus $60 times the number of clients served on the first day of July of the current license year.

(g) A program licensed to provide housing access coordination; behavioral programming; specialist services; companion services; personal support; 24-hour emergency assistance, on-call and personal emergency response; night supervision; homemaker services, excluding providers licensed by the Department of Health under chapter 144A or those providers providing cleaning services only; respite; or independent living skills training; for persons with disabilities or persons age 65 and older under chapter 245D must pay an annual nonrefundable license fee of $750.

(h) A residential program certified by the Department of Health as an intermediate care facility for persons with developmental disabilities ~~(ICF/MR)~~ (ICF/DD) and a noncertified residential program licensed to provide health or rehabilitative services for persons with developmental disabilities shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$535

25 to 49 persons	$735
50 or more persons	$935

(i) A chemical dependency treatment program licensed under Minnesota Rules, parts 9530.6405 to 9530.6505, to provide chemical dependency treatment shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$600
25 to 49 persons	$800
50 to 74 persons	$1,000
75 to 99 persons	$1,200
100 or more persons	$1,400

(j) A chemical dependency program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, to provide detoxification services shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$760
25 to 49 persons	$960
50 or more persons	$1,160

(k) Except for child foster care, a residential facility licensed under Minnesota Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$1,000
25 to 49 persons	$1,100
50 to 74 persons	$1,200
75 to 99 persons	$1,300
100 or more persons	$1,400

(l) A residential facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,525
25 or more persons	$2,725

(m) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$450
25 to 49 persons	$650
50 to 74 persons	$850
75 to 99 persons	$1,050
100 or more persons	$1,250

(n) A program licensed to provide independent living assistance for youth under section 245A.22 shall pay an annual nonrefundable license fee of $1,500.

(o) A private agency licensed to provide foster care and adoption services under Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable license fee of $875.

(p) A program licensed as an adult day care center licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$500
25 to 49 persons	$700
50 to 74 persons	$900
75 to 99 persons	$1,100
100 or more persons	$1,300

(q) A program licensed to provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of $20,000.

(r) A mental health center or mental health clinic requesting certification for purposes of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750 to 9520.0870, shall pay a certification fee of $1,550 per year. If the mental health center or mental health clinic provides services at a primary location with satellite facilities, the satellite facilities shall be certified with the primary location without an additional charge.

(s) The annual license fee charged under this subdivision does not include the temporary licensing surcharge under section 16E.22.

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

Sec. 4. 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. 5. 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. 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.

Sec. 7. Minnesota Statutes 2011 Supplement, section 256B.06, subdivision 4, is amended to read:

Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited to citizens of the United States, qualified noncitizens as defined in this subdivision, and other persons residing lawfully in the United States. Citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) "Qualified noncitizen" means a person who meets one of the following immigration criteria:

(1) admitted for lawful permanent residence according to United States Code, title 8;

(2) admitted to the United States as a refugee according to United States Code, title 8, section 1157;

(3) granted asylum according to United States Code, title 8, section 1158;

(4) granted withholding of deportation according to United States Code, title 8, section 1253(h);

(5) paroled for a period of at least one year according to United States Code, title 8, section 1182(d)(5);

(6) granted conditional entrant status according to United States Code, title 8, section 1153(a)(7);

(7) determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

(8) is a child of a noncitizen determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill, Public Law 104-200; or

(9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public Law 96-422, the Refugee Education Assistance Act of 1980.

(c) All qualified noncitizens who were residing in the United States before August 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation.

(d) Beginning December 1, 1996, qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of this chapter are eligible for medical assistance with federal participation for five years if they meet one of the following criteria:

(1) refugees admitted to the United States according to United States Code, title 8, section 1157;

(2) persons granted asylum according to United States Code, title 8, section 1158;

(3) persons granted withholding of deportation according to United States Code, title 8, section 1253(h);

(4) veterans of the United States armed forces with an honorable discharge for a reason other than noncitizen status, their spouses and unmarried minor dependent children; or

(5) persons on active duty in the United States armed forces, other than for training, their spouses and unmarried minor dependent children.

Beginning July 1, 2010, children and pregnant women who are noncitizens described in paragraph (b) or who are lawfully present in the United States as defined in Code of Federal Regulations, title 8, section 103.12, and who otherwise meet eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation as provided by the federal Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3.

(e) Nonimmigrants who otherwise meet the eligibility requirements of this chapter are eligible for the benefits as provided in paragraphs (f) to (h). For purposes of this subdivision, a "nonimmigrant" is a person in one of the classes listed in United States Code, title 8, section 1101(a)(15).

(f) Payment shall also be made for care and services that are furnished to noncitizens, regardless of immigration status, who otherwise meet the eligibility requirements of this chapter, if such care and services are necessary for the treatment of an emergency medical condition.

(g) For purposes of this subdivision, the term "emergency medical condition" means a medical condition that meets the requirements of United States Code, title 42, section 1396b(v).

(h)(1) Notwithstanding paragraph (g), services that are necessary for the treatment of an emergency medical condition are limited to the following:

(i) services delivered in an emergency room or by an ambulance service licensed under chapter 144E that are directly related to the treatment of an emergency medical condition;

(ii) services delivered in an inpatient hospital setting following admission from an emergency room or clinic for an acute emergency condition; ~~and~~

(iii) follow-up services that are directly related to the original service provided to treat the emergency medical condition and are covered by the global payment made to the provider~~.~~;

(iv) administration of dialysis services provided in a hospital or freestanding dialysis facility; or

(v) surgery and administration of chemotherapy, radiation, and related services necessary to treat cancer provided to recipients with a diagnosis of cancer that is not in remission and requires surgery, chemotherapy, or radiation treatment.

(2) Services for the treatment of emergency medical conditions do not include the following unless the services are part of the treatment plan for a recipient with a cancer diagnosis and are directly related to cancer treatment as in clause (1), item (v):

(i) services delivered in an emergency room or inpatient setting to treat a nonemergency condition;

(ii) organ transplants, stem cell transplants, and related care;

(iii) services for routine prenatal care;

(iv) continuing care, including long-term care, nursing facility services, home health care, adult day care, day training, or supportive living services;

(v) elective surgery;

(vi) outpatient prescription drugs, unless the drugs are administered or dispensed as part of an emergency room visit;

(vii) preventative health care and family planning services;

~~(viii) dialysis;~~

~~(ix) chemotherapy or therapeutic radiation services;~~

~~(x)~~ (viii) rehabilitation services;

~~(xi)~~ (ix) physical, occupational, or speech therapy;

~~(xii)~~ (x) transportation services;

~~(xiii)~~ (xi) case management;

~~(xiv)~~ (xii) prosthetics, orthotics, durable medical equipment, or medical supplies;

~~(xv)~~ (xiii) dental services;

~~(xvi)~~ (xiv) hospice care;

~~(xvii)~~ (xv) audiology services and hearing aids;

~~(xviii)~~ (xvi) podiatry services;

~~(xix)~~ (xvii) chiropractic services;

~~(xx)~~ (xviii) immunizations;

~~(xxi)~~ (xix) vision services and eyeglasses;

~~(xxii)~~ (xx) waiver services;

~~(xxiii)~~ (xxi) individualized education programs; or

~~(xxiv)~~ (xxii) chemical dependency treatment.

(i) Beginning July 1, 2009, pregnant noncitizens who are undocumented, nonimmigrants, or lawfully present in the United States as defined in Code of Federal Regulations, title 8, section 103.12, are not covered by a group health plan or health insurance coverage according to Code of Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance through the period of pregnancy, including labor and delivery, and 60 days postpartum, to the extent federal funds are available under title XXI of the Social Security Act, and the state children's health insurance program.

(j) Beginning October 1, 2003, persons who are receiving care and rehabilitation services from a nonprofit center established to serve victims of torture and are otherwise ineligible for medical assistance under this chapter are eligible for medical assistance without federal financial participation. These individuals are eligible only for the period during which they are receiving services from the center. Individuals eligible under this paragraph shall not be required to participate in prepaid medical assistance.

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

Sec. 8. Minnesota Statutes 2011 Supplement, section 256B.0659, subdivision 11, is amended to read:

Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must meet the following requirements:

(1) be at least 18 years of age with the exception of persons who are 16 or 17 years of age with these additional requirements:

(i) supervision by a qualified professional every 60 days; and

(ii) employment by only one personal care assistance provider agency responsible for compliance with current labor laws;

(2) be employed by a personal care assistance provider agency;

(3) enroll with the department as a personal care assistant after clearing a background study. Except as provided in subdivision 11a, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study on the personal care assistant under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

(i) not disqualified under section 245C.14; or

(ii) is disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22;

(4) be able to effectively communicate with the recipient and personal care assistance provider agency;

(5) be able to provide covered personal care assistance services according to the recipient's personal care assistance care plan, respond appropriately to recipient needs, and report changes in the recipient's condition to the supervising qualified professional or physician;

(6) not be a consumer of personal care assistance services;

(7) maintain daily written records including, but not limited to, time sheets under subdivision 12;

(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. Personal care assistant training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of personal care assistants including information about assistance with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices, fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

(9) complete training and orientation on the needs of the recipient within the first seven days after the services begin; and

(10) be limited to providing and being paid for up to 275 hours per month, except that this limit shall be 275 hours per month for the period July 1, 2009, through June 30, 2011, of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with. The number of hours worked per day shall not be disallowed by the department unless in violation of the law.

(b) A legal guardian may be a personal care assistant if the guardian is not being paid for the guardian services and meets the criteria for personal care assistants in paragraph (a).

(c) Persons who do not qualify as a personal care assistant include parents and stepparents of minors, spouses, paid legal guardians, family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a, or staff of a residential setting. ~~When the personal care assistant is a relative of the recipient, the commissioner shall pay 80 percent of the provider rate. For purposes of this section, relative means the~~

~~parent or adoptive parent of an adult child, a sibling aged 16 years or older, an adult child, a grandparent, or a grandchild.~~

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

Sec. 9. Minnesota Statutes 2011 Supplement, section 256B.0659, subdivision 28, is amended to read:

Subd. 28. **Personal care assistance provider agency; required documentation.** (a) Required documentation must be completed and kept in the personal care assistance provider agency file or the recipient's home residence. The required documentation consists of:

(1) employee files, including:

(i) applications for employment;

(ii) background study requests and results;

(iii) orientation records about the agency policies;

(iv) trainings completed with demonstration of competence;

(v) supervisory visits;

(vi) evaluations of employment; and

(vii) signature on fraud statement;

(2) recipient files, including:

(i) demographics;

(ii) emergency contact information and emergency backup plan;

(iii) personal care assistance service plan;

(iv) personal care assistance care plan;

(v) month-to-month service use plan;

(vi) all communication records;

(vii) start of service information, including the written agreement with recipient; and

(viii) date the home care bill of rights was given to the recipient;

(3) agency policy manual, including:

(i) policies for employment and termination;

(ii) grievance policies with resolution of consumer grievances;

(iii) staff and consumer safety;

(iv) staff misconduct; and

(v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and resolution of consumer grievances;

(4) time sheets for each personal care assistant along with completed activity sheets for each recipient served; and

(5) agency marketing and advertising materials and documentation of marketing activities and costs~~; and~~.

~~(6) for each personal care assistant, whether or not the personal care assistant is providing care to a relative as defined in subdivision 11.~~

(b) The commissioner may assess a fine of up to $500 on provider agencies that do not consistently comply with the requirements of this subdivision.

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

Sec. 10. 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 provided under section 245A.03, subdivision 7, paragraph (a), clauses (3) and (4), and the statewide 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~~ 2013. The results of the assessments will be used in the statewide needs determination process. Implementation of the statewide licensed capacity reduction will begin on July 1, 2013.

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

Sec. 11. 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)~~,~~ and 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 2013~~ and $36,744,000 in fiscal year ~~2014 and thereafter~~ 2013.

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

Sec. 12. Laws 2011, First Special Session chapter 9, article 7, section 52, is amended to read:

Sec. 52. **IMPLEMENT NURSING HOME LEVEL OF CARE CRITERIA.**

The commissioner shall seek any necessary federal approval in order to implement the changes to the level of care criteria in Minnesota Statutes, section 144.0724, subdivision 11, on or after July 1, 2012 for adults and children.

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

Sec. 13. Laws 2011, First Special Session chapter 9, article 7, section 54, is amended to read:

Sec. 54. **CONTINGENCY PROVIDER RATE AND GRANT REDUCTIONS.**

(a) Notwithstanding any other rate reduction in this article, the commissioner of human services shall decrease grants, allocations, reimbursement rates, individual limits, and rate limits, as applicable, by 1.67 percent effective July 1, 2012, for services rendered on or after those dates. County or tribal contracts for services specified in this section must

be amended to pass through these rate reductions within 60 days of the effective date of the decrease, and must be retroactive from the effective date of the rate decrease.

(b) The rate changes described in this section must be provided to:

(1) home and community-based waivered services for persons with developmental disabilities or related conditions, including consumer-directed community supports, under Minnesota Statutes, section 256B.501;

(2) home and community-based waivered services for the elderly, including consumer-directed community supports, under Minnesota Statutes, section 256B.0915;

(3) waivered services under community alternatives for disabled individuals, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(4) community alternative care waivered services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(5) traumatic brain injury waivered services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(6) nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

(7) personal care services and qualified professional supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

(8) private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7;

(9) day training and habilitation services for adults with developmental disabilities or related conditions, under Minnesota Statutes, sections 252.40 to 252.46, including the additional cost of rate adjustments on day training and habilitation services, provided as a social service under Minnesota Statutes, section 256M.60; and

(10) alternative care services under Minnesota Statutes, section 256B.0913.

(c) A managed care plan receiving state payments for the services in this section must include these decreases in their payments to providers. To implement the rate reductions in this section, capitation rates paid by the commissioner to managed care organizations under Minnesota Statutes, section 256B.69, shall reflect a ~~2.34~~ 3.34 percent reduction for the specified services for the period of January 1, 2013, through June 30, 2013, and a 1.67 percent reduction for those services on and after July 1, 2013.

The above payment rate reduction, allocation rates, and rate limits shall expire for services rendered on December 31, 2013.

(d) If the federal approval required under Laws 2011, First Special Session chapter 9, article 7, section 52, is obtained after June 30, 2012, on the first day of the month that

is 60 days after receipt of federal approval, the commissioner of human services shall increase payment rates for grants, allocations, reimbursement rates, individual limits, and rate limits by 1.67 percent for those programs and services that received a rate reduction under this section or under Minnesota Statutes, section 256B.5012, subdivision 13.

(e) If the federal approval required under Laws 2011, First Special Session chapter 9, article 7, section 52, is obtained after June 30, 2012, but before the 2013 managed care contracts are finalized, the commissioner of human services shall adjust the capitation for the period January 1, 2013, through June 30, 2013, based on the date the approval is obtained and shall not impose the 1.67 percent rate reduction under paragraph (c) on or after July 1, 2013.

(f) If the federal approval required under Laws 2011, First Special Session chapter 9, article 7, section 52, is obtained after the 2013 managed care contracts are finalized, the commissioner of human services shall amend managed care contracts to increase the capitation to provide for a 1.67 percent increase to providers that received a decrease under paragraph (c). This capitation increase is effective on the first day of the month that is 60 days after receipt of federal approval.

EFFECTIVE DATE. This section is effective July 1, 2012, if the federal approval required under section 11 has not been obtained by June 30, 2012.

Sec. 14. 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, lead agencies must reduce rates in effect on January 1, 2011, by ~~ten~~ up to five 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. 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

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

Sec. 15. **GRANTS FOR HOUSING ACCESS SERVICES.**

Notwithstanding Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision 4, paragraph (k), the fiscal year 2012 appropriation for grants for housing access services shall be available in fiscal year 2013 for the same purposes.

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

ARTICLE 2

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	$	1,284,000	$ 26,941,000	$ 28,225,000
State Government Special Revenue		-0-	638,000	638,000
Total	**$**	**1,284,000**	**$ 27,579,000**	**$ 28,863,000**

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**	**$ 1,284,000**	**$ 27,016,000**

Appropriations by Fund

	2012	2013
General	1,284,000	26,378,000
State Government Special Revenue	-0-	638,000

Subd. 2. **Central Office Operations**

(a) **Operations**

Appropriations by Fund

	2012	2013
General	107,000	6,000
State Government Special Revenue	-0-	638,000

(b) **Health Care**	5,000	(98,000)

Base Level Adjustment. The general fund base for health care is decreased by $82,000 in fiscal years 2014 and 2015.

(c) **Continuing Care** -0- 48,000

Base Level Adjustment. The general fund base for continuing care is decreased by $152,000 in fiscal years 2014 and 2015.

Subd. 3. **Forecasted Programs**

Medical Assistance Grants 623,000 21,918,000

Subd. 4. **Grant Programs**

(a) **Children and Community Services Grants** -0- 542,000

White Earth Human Services Transfer Grant. Of the general fund appropriation, $542,000 in fiscal year 2013 is for a grant to the White Earth tribe to support development of local capacity for effective and efficient delivery of human services to tribal members and their families. This appropriation is added to the base.

(b) **Aging and Adult Services Grants** -0- 999,000

Essential Community Support grants. This is a onetime appropriation in fiscal year 2013 and does not affect the fiscal year 2014 and 2015 base for these grants.

(c) **Disabilities Grants** -0- 250,000

Needs assessments. This appropriation is for the needs assessments under Minnesota Statutes, sections 245A.03, subdivision 7, and 256B.49, subdivision 15. This is a onetime appropriation.

Subd. 5. **State-Operated Services**

SOS Mental Health 549,000 2,713,000

Minnesota Specialty Health Services, Willmar site. $549,000 in fiscal year 2012 and $2,713,000 in fiscal year 2013 is to continue operations of the Minnesota Health Services, Willmar site. These appropriations are onetime. Closure of the facility shall not occur prior to June 30, 2013.

Sec. 4. **COMMISSIONER OF HEALTH** **$ 0 $ 563,000**

$563,000 in fiscal year 2013 is to increase inspection and oversight of licensed home care providers under Minnesota Statutes, chapter 144A. This appropriation is added to the base.

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.

APPENDIX
Article locations in 12-3996