SENATE
STATE OF MINNESOTA
EIGHTY-SEVENTH LEGISLATURE

S.F. No. 2092

(SENATE AUTHORS: HANN)

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02/27/2012	3957	Introduction and first reading Referred to Health and Human Services

A bill for an act

relating to human services; modifying parental contributions for certain disability services; modifying state agency hearings related to the personal care assistance program; modifying assessment and support planning; modifying certain congregate rate reductions; modifying consultation for housing with services; developing the Community First Choice Option; modifying the foster care licensing moratorium; modifying residential settings for home and community-based services; amending Minnesota Statutes 2010, sections 252.27, subdivision 2a; 256B.0659, by adding a subdivision; Minnesota Statutes 2011 Supplement, sections 245A.03, subdivision 7; 256.045, subdivision 3; 256B.0911, subdivisions 3a, 3c; Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision 3; proposing coding for new law in Minnesota Statutes, chapter 256B.

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

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 licensed capacity for the home if the license holder has a total capacity of 24 or more beds. License holders who have their capacity decreased under this paragraph may consolidate homes as necessary. A decreased licensed capacity according to this paragraph is not subject to appeal under this chapter.

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

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

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

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

(2) if the adjusted gross income is equal to or greater than 175 percent of federal poverty guidelines and less than or equal to ~~545~~ 525 percent of federal poverty guidelines,

the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at one percent of adjusted gross income at 175 percent of federal poverty guidelines and increases to ~~7.5~~ eight percent of adjusted gross income for those with adjusted gross income up to ~~545~~ 525 percent of federal poverty guidelines;

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

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

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

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

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

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

(e) The contribution shall be explained in writing to the parents at the time eligibility for services is being determined. The contribution shall be made on a monthly basis effective with the first month in which the child receives services. Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of

services provided, the local agency or the state shall reimburse that excess amount to the parents, either by direct reimbursement if the parent is no longer required to pay a contribution, or by a reduction in or waiver of parental fees until the excess amount is exhausted. All reimbursements must include a notice that the amount reimbursed may be taxable income if the parent paid for the parent's fees through an employer's health care flexible spending account under the Internal Revenue Code, section 125, and that the parent is responsible for paying the taxes owed on the amount reimbursed.

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

(g) Parents of a minor child who do not live with each other shall each pay the contribution required under paragraph (a). An amount equal to the annual court-ordered child support payment actually paid on behalf of the child receiving services shall be deducted from the adjusted gross income of the parent making the payment prior to calculating the parental contribution under paragraph (b).

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

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

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

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

(2) the insurer denied insurance;

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

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

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

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

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

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

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

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

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

~~(5) if the adjusted gross income is equal to or greater than 900 percent of federal poverty guidelines, the parental contribution shall be 13.5 percent of adjusted gross income. If the child lives with the parent, the annual adjusted gross income is reduced by~~

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

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

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

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

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

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

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

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

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

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

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

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

(10) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, following a reconsideration decision issued under section 245C.23, on the basis of serious or recurring maltreatment; a preponderance of the

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

(11) any person with an outstanding debt resulting from receipt of public assistance, medical care, or the federal Food Stamp Act who is contesting a setoff claim by the Department of Human Services or a county agency. The scope of the appeal is the validity of the claimant agency's intention to request a setoff of a refund under chapter 270A against the debt.

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

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

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

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

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

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

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

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

Sec. 4. Minnesota Statutes 2010, section 256B.0659, is amended by adding a subdivision to read:

Subd. 31. **Appeals.** (a) A recipient who is adversely affected by the reduction, suspension, denial, or termination of services under this section may appeal the decision according to section 256.045. The appeal must be in writing and identify the specific issues the recipient would like to have considered in the appeal hearing and a summary of the basis, with supporting professional documentation if available, for contesting the decision.

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

Sec. 5. Minnesota Statutes 2011 Supplement, section 256B.0911, subdivision 3a, is amended to read:

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

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

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

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

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

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

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

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

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

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

(3) information about Minnesota health care programs;

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

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

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

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

(i) Face-to-face assessment completed as part of eligibility determination for the alternative care, elderly waiver, community alternatives for disabled individuals, community alternative care, and traumatic brain injury waiver programs under sections 256B.0915, 256B.0917, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment. The effective eligibility start date for these programs can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated in a face-to-face visit and documented in the department's Medicaid Management Information

System (MMIS). The effective date of program eligibility in this case cannot be prior to the date the updated assessment is completed.

Sec. 6. Minnesota Statutes 2011 Supplement, section 256B.0911, subdivision 3c, is amended to read:

Subd. 3c. **Consultation for housing with services.** (a) The purpose of long-term care consultation for registered housing with services is to support persons with current or anticipated long-term care needs in making informed choices among options that include the most cost-effective and least restrictive settings. Prospective residents maintain the right to choose housing with services or assisted living if that option is their preference.

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

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

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

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

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

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

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

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

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

(d) Exemptions from the consultation requirement under paragraph (b) and emergency admissions to registered housing with services establishments prior to consultation under paragraph (b) are permitted according to policies established by the commissioner.

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

Sec. 7. **[256B.492] HOME AND COMMUNITY-BASED SETTINGS.**

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

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

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

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

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

(iii) for settings that meet this definition, individuals with disabilities may reside in up to 20 percent of the units.

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

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

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

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

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

(5) have the qualities of an institution, unless specifically required in the individual's plan developed with the lead agency case manager and legal guardian. The qualities of an institution include, but are not limited to:

(i) regimented meal and sleep times;

(ii) limitations on visitors; and

(iii) lack of privacy.

Sec. 8. 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 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 may reduce services for persons with lower needs on the CADI and DD waivers if appropriate based on an assessment of needs. This reduction must be spread proportionately across the CADI and DD waivers based on the number of persons enrolled in each waiver. Lead agencies must adjust contracts within 60

days of the effective date. However, no foster care setting shall have their overall Medical Assistance reimbursement reduced by more than four percent.

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 total spending by five percent through reductions in component rates and service rate limits. Component rates and service rate limits shall be reduced as follows:

(1) customized living and 24-hour customized living facilities in which 60 percent or more of their residents are receiving elderly waiver services shall have their component rates and service rate limits reduced by three percent;

(2) customized living facilities in which more than ten percent but less than 60 percent of their residents are receiving elderly waiver services shall have their component rates and

service rate limits reduced by five percent; and

(3) customized living and 24-hour customized living facilities in which ten percent or fewer of their residents are receiving elderly waiver services shall have their component rates and service rate limits reduced by eight percent.

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. 9. **COMMUNITY FIRST CHOICE OPTION.**

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

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

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

(d) The commissioner shall consult with stakeholders, including persons with disabilities and seniors, who represent a range of disabilities, ages, cultures, and geographic locations, their families and guardians, as well as representatives of advocacy organizations, lead agencies, direct support staff, and a variety of service provider groups.