

SENATE
STATE OF MINNESOTA
EIGHTY-SEVENTH LEGISLATURE **S.F. No. 2486**

(SENATE AUTHORS: LOUREY)

DATE	D-PG	OFFICIAL STATUS
03/15/2012	4476	Introduction and first reading Referred to Health and Human Services See SF2093, Art. 1, Sec. 2; Art. 4, Sec. 13-14, 30; Art. 6; Art. 7, Sec. 3, 5

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;

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

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

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

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

2.11 (b) The commissioner shall determine the need for newly licensed foster care homes
2.12 as defined under this subdivision. As part of the determination, the commissioner shall
2.13 consider the availability of foster care capacity in the area in which the licensee seeks to
2.14 operate, and the recommendation of the local county board. The determination by the
2.15 commissioner must be final. A determination of need is not required for a change in
2.16 ownership at the same address.

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

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

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

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

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

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

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

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

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

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

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

3.12 (e) When a foster care recipient moves out of a foster home that is not the primary
3.13 residence of the license holder according to section 256B.49, subdivision 15, paragraph
3.14 (f), the county shall immediately inform the Department of Human Services Licensing
3.15 Division, and the department shall immediately decrease the statewide licensed capacity
3.16 for the home foster care settings where the physical location is not the primary residence
3.17 of the license holder. A decreased licensed capacity according to this paragraph is not
3.18 subject to appeal under this chapter. A needs determination process, managed at the state
3.19 level, with county input, will determine where the reduced capacity will occur.

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

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

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

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

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

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

4.11 (2) For a license to provide supported employment, crisis respite, or
4.12 semi-independent living services to persons with developmental disabilities under chapter
4.13 245B, an applicant shall submit a single application to provide services statewide.

4.14 (3) For a license to provide independent living assistance for youth under section
4.15 245A.22, an applicant shall submit a single application to provide services statewide.

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

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

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

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

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

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

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

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

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

5.5		Child Care Center
5.6	Licensed Capacity	License Fee
5.7	1 to 24 persons	\$200
5.8	25 to 49 persons	\$300
5.9	50 to 74 persons	\$400
5.10	75 to 99 persons	\$500
5.11	100 to 124 persons	\$600
5.12	125 to 149 persons	\$700
5.13	150 to 174 persons	\$800
5.14	175 to 199 persons	\$900
5.15	200 to 224 persons	\$1,000
5.16	225 or more persons	\$1,100

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

5.22	Licensed Capacity	License Fee
5.23	1 to 24 persons	\$800
5.24	25 to 49 persons	\$1,000
5.25	50 to 74 persons	\$1,200
5.26	75 to 99 persons	\$1,400
5.27	100 to 124 persons	\$1,600
5.28	125 to 149 persons	\$1,800
5.29	150 or more persons	\$2,000

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

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

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

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

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

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

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

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

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

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

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

Licensed Capacity	License Fee
1 to 24 persons	\$535

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7.1	25 to 49 persons	\$735
7.2	50 or more persons	\$935

7.3 (i) A chemical dependency treatment program licensed under Minnesota Rules, parts
7.4 9530.6405 to 9530.6505, to provide chemical dependency treatment shall pay an annual
7.5 nonrefundable license fee based on the following schedule:

7.6	Licensed Capacity	License Fee
7.7	1 to 24 persons	\$600
7.8	25 to 49 persons	\$800
7.9	50 to 74 persons	\$1,000
7.10	75 to 99 persons	\$1,200
7.11	100 or more persons	\$1,400

7.12 (j) A chemical dependency program licensed under Minnesota Rules, parts
7.13 9530.6510 to 9530.6590, to provide detoxification services shall pay an annual
7.14 nonrefundable license fee based on the following schedule:

7.15	Licensed Capacity	License Fee
7.16	1 to 24 persons	\$760
7.17	25 to 49 persons	\$960
7.18	50 or more persons	\$1,160

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

7.22	Licensed Capacity	License Fee
7.23	1 to 24 persons	\$1,000
7.24	25 to 49 persons	\$1,100
7.25	50 to 74 persons	\$1,200
7.26	75 to 99 persons	\$1,300
7.27	100 or more persons	\$1,400

7.28 (l) A residential facility licensed under Minnesota Rules, parts 9520.0500 to
7.29 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license
7.30 fee based on the following schedule:

7.31	Licensed Capacity	License Fee
7.32	1 to 24 persons	\$2,525
7.33	25 or more persons	\$2,725

7.34 (m) A residential facility licensed under Minnesota Rules, parts 9570.2000 to
7.35 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable
7.36 license fee based on the following schedule:

	Licensed Capacity	License Fee
8.1		
8.2	1 to 24 persons	\$450
8.3	25 to 49 persons	\$650
8.4	50 to 74 persons	\$850
8.5	75 to 99 persons	\$1,050
8.6	100 or more persons	\$1,250

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

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

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

	Licensed Capacity	License Fee
8.15		
8.16	1 to 24 persons	\$500
8.17	25 to 49 persons	\$700
8.18	50 to 74 persons	\$900
8.19	75 to 99 persons	\$1,100
8.20	100 or more persons	\$1,300

8.21 (q) A program licensed to provide treatment services to persons with sexual
8.22 psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts
8.23 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of \$20,000.

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

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

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

8.33 Sec. 4. Minnesota Statutes 2010, section 256B.056, subdivision 1a, is amended to read:

8.34 Subd. 1a. **Income and assets generally.** Unless specifically required by state
8.35 law or rule or federal law or regulation, the methodologies used in counting income
8.36 and assets to determine eligibility for medical assistance for persons whose eligibility

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

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

9.18 Sec. 5. Minnesota Statutes 2011 Supplement, section 256B.056, subdivision 3, is
9.19 amended to read:

9.20 Subd. 3. **Asset limitations for individuals and families.** (a) To be eligible for
9.21 medical assistance, a person must not individually own more than \$3,000 in assets, or if a
9.22 member of a household with two family members, husband and wife, or parent and child,
9.23 the household must not own more than \$6,000 in assets, plus \$200 for each additional
9.24 legal dependent. In addition to these maximum amounts, an eligible individual or family
9.25 may accrue interest on these amounts, but they must be reduced to the maximum at the
9.26 time of an eligibility redetermination. The accumulation of the clothing and personal
9.27 needs allowance according to section 256B.35 must also be reduced to the maximum at
9.28 the time of the eligibility redetermination. The value of assets that are not considered in
9.29 determining eligibility for medical assistance is the value of those assets excluded under
9.30 the supplemental security income program for aged, blind, and disabled persons, with
9.31 the following exceptions:

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

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

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

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

10.7 (5) for a person who no longer qualifies as an employed person with a disability due
10.8 to loss of earnings, assets allowed while eligible for medical assistance under section
10.9 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month
10.10 of ineligibility as an employed person with a disability, to the extent that the person's total
10.11 assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph
10.12 (d); ~~and~~

10.13 (6) when a person enrolled in medical assistance under section 256B.057, subdivision
10.14 9, is age 65 or older and has been enrolled during each of the 24 consecutive months
10.15 before the person's 65th birthday, the assets owned by the person and the person's spouse
10.16 must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d),
10.17 when determining eligibility for medical assistance under section 256B.055, subdivision
10.18 7. The income of a spouse of a person enrolled in medical assistance under section
10.19 256B.057, subdivision 9, during each of the 24 consecutive months before the person's
10.20 65th birthday must be disregarded when determining eligibility for medical assistance
10.21 under section 256B.055, subdivision 7. Persons eligible under this clause are not subject to
10.22 the provisions in section 256B.059. A person whose 65th birthday occurs in 2012 or 2013
10.23 is required to have qualified for medical assistance under section 256B.057, subdivision 9,
10.24 prior to age 65 for at least 20 months in the 24 months prior to reaching age 65.

10.25 (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision
10.26 15.

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

10.28 Sec. 6. Minnesota Statutes 2011 Supplement, section 256B.057, subdivision 9, is
10.29 amended to read:

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

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

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

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

11.1 ~~(4)~~ (3) pays a premium and other obligations under paragraph (e).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13.30 (c) All qualified noncitizens who were residing in the United States before August
13.31 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for
13.32 medical assistance with federal financial participation.

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

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

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

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

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

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

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

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

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

14.25 (g) For purposes of this subdivision, the term "emergency medical condition" means
14.26 a medical condition that meets the requirements of United States Code, title 42, section
14.27 1396b(v).

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

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

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

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

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

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

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

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

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

15.15 (iii) services for routine prenatal care;

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

15.18 (v) elective surgery;

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

15.21 (vii) preventative health care and family planning services;

15.22 ~~(viii) dialysis;~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17.24 (10) be limited to providing and being paid for up to 275 hours per month, except
17.25 that this limit shall be 275 hours per month for the period July 1, 2009, through June 30,
17.26 2011, of personal care assistance services regardless of the number of recipients being
17.27 served or the number of personal care assistance provider agencies enrolled with. The
17.28 number of hours worked per day shall not be disallowed by the department unless in
17.29 violation of the law.

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

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

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

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

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

18.6 Subd. 28. **Personal care assistance provider agency; required documentation.**

18.7 (a) Required documentation must be completed and kept in the personal care assistance
18.8 provider agency file or the recipient's home residence. The required documentation
18.9 consists of:

18.10 (1) employee files, including:

18.11 (i) applications for employment;

18.12 (ii) background study requests and results;

18.13 (iii) orientation records about the agency policies;

18.14 (iv) trainings completed with demonstration of competence;

18.15 (v) supervisory visits;

18.16 (vi) evaluations of employment; and

18.17 (vii) signature on fraud statement;

18.18 (2) recipient files, including:

18.19 (i) demographics;

18.20 (ii) emergency contact information and emergency backup plan;

18.21 (iii) personal care assistance service plan;

18.22 (iv) personal care assistance care plan;

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

18.24 (vi) all communication records;

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

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

18.27 (3) agency policy manual, including:

18.28 (i) policies for employment and termination;

18.29 (ii) grievance policies with resolution of consumer grievances;

18.30 (iii) staff and consumer safety;

18.31 (iv) staff misconduct; and

18.32 (v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and

18.33 resolution of consumer grievances;

18.34 (4) time sheets for each personal care assistant along with completed activity sheets

18.35 for each recipient served; and

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

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

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

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

19.8 Sec. 10. Minnesota Statutes 2011 Supplement, section 256B.49, subdivision 15,
19.9 is amended to read:

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

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

19.15 (2) meets the assessed needs of the recipient;

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

19.17 (4) promotes independence;

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

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

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

19.31 Within ten days following an assessment, a comprehensive transitional service plan
19.32 must be developed incorporating elements of a comprehensive functional assessment and
19.33 including short-term measurable outcomes and timelines for achievement of and reporting
19.34 on these outcomes. Functional milestones must also be identified and reported according
19.35 to the timelines agreed upon by the transitional service planning team. In addition, the

20.1 comprehensive transitional service plan must identify additional supports that may assist
20.2 in the achievement of the fundamental service outcome such as the development of greater
20.3 natural community support, increased collaboration among agencies, and technological
20.4 supports.

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

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

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

20.19 (d) Following one year of transitional services, the transitional services planning
20.20 team will make a determination as to whether or not the individual receiving services
20.21 requires the current level of continuous and consistent support in order to maintain the
20.22 recipient's current level of functioning. Recipients who are determined to have not had
20.23 a significant change in functioning for 12 months must move from a transitional to a
20.24 maintenance service plan. Recipients on a maintenance service plan must be reassessed
20.25 to determine if the recipient would benefit from a transitional service plan at least every
20.26 12 months and at other times when there has been a significant change in the recipient's
20.27 functioning. This assessment should consider any changes to technological or natural
20.28 community supports.

20.29 (e) When a county is evaluating denials, reductions, or terminations of home and
20.30 community-based services under section 256B.49 for an individual, the case manager
20.31 shall offer to meet with the individual or the individual's guardian in order to discuss the
20.32 prioritization of service needs within the individualized service plan, comprehensive
20.33 transitional service plan, or maintenance service plan. The reduction in the authorized
20.34 services for an individual due to changes in funding for waived services may not exceed
20.35 the amount needed to ensure medically necessary services to meet the individual's health,
20.36 safety, and welfare.

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21.1 (f) At the time of reassessment, local agency case managers shall assess each
21.2 recipient of community alternatives for disabled individuals or traumatic brain injury
21.3 waived services currently residing in a licensed adult foster home that is not the primary
21.4 residence of the license holder, or in which the license holder is not the primary caregiver,
21.5 to determine if that recipient could appropriately be served in a community-living setting.
21.6 If appropriate for the recipient, the case manager shall offer the recipient, through a
21.7 person-centered planning process, the option to receive alternative housing and service
21.8 options. In the event that the recipient chooses to transfer from the adult foster home,
21.9 the vacated bed shall not be filled with another recipient of waiver services and group
21.10 residential housing, unless provided under section 245A.03, subdivision 7, paragraph (a),
21.11 clauses (3) and (4), and the statewide licensed capacity shall be reduced accordingly. If
21.12 the adult foster home becomes no longer viable due to these transfers, the county agency,
21.13 with the assistance of the department, shall facilitate a consolidation of settings or closure.
21.14 This reassessment process shall be completed by June 30, ~~2012~~ 2013. The results of the
21.15 assessments will be used in the statewide needs determination process. Implementation of
21.16 the statewide licensed capacity reduction will begin on July 1, 2013.

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

21.18 Sec. 11. Minnesota Statutes 2011 Supplement, section 256B.69, subdivision 5c,
21.19 is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23.9 (3) waived services under community alternatives for disabled individuals,
23.10 including consumer-directed community supports, under Minnesota Statutes, section
23.11 256B.49;

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

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

23.16 (6) nursing services and home health services under Minnesota Statutes, section
23.17 256B.0625, subdivision 6a;

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

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

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

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

23.27 (c) A managed care plan receiving state payments for the services in this section
23.28 must include these decreases in their payments to providers. To implement the rate
23.29 reductions in this section, capitation rates paid by the commissioner to managed care
23.30 organizations under Minnesota Statutes, section 256B.69, shall reflect a ~~2.34~~ 3.34 percent
23.31 reduction for the specified services for the period of January 1, 2013, through June 30,
23.32 2013, and a 1.67 percent reduction for those services on and after July 1, 2013.

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

23.35 (d) If the federal approval required under Laws 2011, First Special Session chapter
23.36 9, article 7, section 52, is obtained after June 30, 2012, on the first day of the month that

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

24.5 (e) If the federal approval required under Laws 2011, First Special Session chapter
24.6 9, article 7, section 52, is obtained after June 30, 2012, but before the 2013 managed care
24.7 contracts are finalized, the commissioner of human services shall adjust the capitation for
24.8 the period January 1, 2013, through June 30, 2013, based on the date the approval is
24.9 obtained and shall not impose the 1.67 percent rate reduction under paragraph (c) on or
24.10 after July 1, 2013.

24.11 (f) If the federal approval required under Laws 2011, First Special Session chapter
24.12 9, article 7, section 52, is obtained after the 2013 managed care contracts are finalized,
24.13 the commissioner of human services shall amend managed care contracts to increase the
24.14 capitation to provide for a 1.67 percent increase to providers that received a decrease
24.15 under paragraph (c). This capitation increase is effective on the first day of the month that
24.16 is 60 days after receipt of federal approval.

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

24.19 Sec. 14. Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision
24.20 3, is amended to read:

24.21 **Subd. 3. Forecasted Programs**

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

24.24 **(a) MFIP/DWP Grants**

	Appropriations by Fund	
24.25		
24.26	General	84,680,000 91,978,000
24.27	Federal TANF	84,425,000 75,417,000

24.28 **(b) MFIP Child Care Assistance Grants** 55,456,000 30,923,000

24.29 **(c) General Assistance Grants** 49,192,000 46,938,000

24.30 **General Assistance Standard.** The
24.31 commissioner shall set the monthly standard
24.32 of assistance for general assistance units
24.33 consisting of an adult recipient who is

25.1 childless and unmarried or living apart
 25.2 from parents or a legal guardian at \$203.
 25.3 The commissioner may reduce this amount
 25.4 according to Laws 1997, chapter 85, article
 25.5 3, section 54.

25.6 **Emergency General Assistance.** The
 25.7 amount appropriated for emergency general
 25.8 assistance funds is limited to no more
 25.9 than \$6,689,812 in fiscal year 2012 and
 25.10 \$6,729,812 in fiscal year 2013. Funds
 25.11 to counties shall be allocated by the
 25.12 commissioner using the allocation method
 25.13 specified in Minnesota Statutes, section
 25.14 256D.06.

25.15	(d) Minnesota Supplemental Aid Grants	38,095,000	39,120,000
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25.16	(e) Group Residential Housing Grants	121,080,000	129,238,000
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25.17	(f) MinnesotaCare Grants	295,046,000	317,272,000
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25.18 This appropriation is from the health care
 25.19 access fund.

25.20	(g) Medical Assistance Grants	4,501,582,000	4,437,282,000
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25.21 **Managed Care Incentive Payments.** The
 25.22 commissioner shall not make managed care
 25.23 incentive payments for expanding preventive
 25.24 services during fiscal years beginning July 1,
 25.25 2011, and July 1, 2012.

25.26 **Reduction of Rates for Congregate**
 25.27 **Living for Individuals with Lower Needs.**
 25.28 Beginning October 1, 2011, lead agencies
 25.29 must reduce rates in effect on January 1,
 25.30 2011, by ~~ten~~ up to five percent for individuals
 25.31 with lower needs living in foster care settings
 25.32 where the license holder does not share
 25.33 the residence with recipients on the CADI
 25.34 and DD waivers and customized living

26.1 settings for CADI. Lead agencies must adjust
26.2 contracts within 60 days of the effective date.

26.3 **Reduction of Lead Agency Waiver**

26.4 **Allocations to Implement Rate Reductions**
26.5 **for Congregate Living for Individuals**

26.6 **with Lower Needs.** Beginning October 1,
26.7 2011, the commissioner shall reduce lead
26.8 agency waiver allocations to implement the
26.9 reduction of rates for individuals with lower
26.10 needs living in foster care settings where the
26.11 license holder does not share the residence
26.12 with recipients on the CADI and DD waivers
26.13 and customized living settings for CADI.

26.14 **Reduce customized living and 24-hour**
26.15 **customized living component rates.**

26.16 Effective July 1, 2011, the commissioner
26.17 shall reduce elderly waiver customized living
26.18 and 24-hour customized living component
26.19 service spending by five percent through
26.20 reductions in component rates and service
26.21 rate limits. The commissioner shall adjust
26.22 the elderly waiver capitation payment
26.23 rates for managed care organizations paid
26.24 under Minnesota Statutes, section 256B.69,
26.25 subdivisions 6a and 23, to reflect reductions
26.26 in component spending for customized living
26.27 services and 24-hour customized living
26.28 services under Minnesota Statutes, section
26.29 256B.0915, subdivisions 3e and 3h, for the
26.30 contract period beginning January 1, 2012.

26.31 To implement the reduction specified in
26.32 this provision, capitation rates paid by the
26.33 commissioner to managed care organizations
26.34 under Minnesota Statutes, section 256B.69,
26.35 shall reflect a ten percent reduction for the
26.36 specified services for the period January 1,

27.1 2012, to June 30, 2012, and a five percent
27.2 reduction for those services on or after July
27.3 1, 2012.

27.4 **Limit Growth in the Developmental**
27.5 **Disability Waiver.** The commissioner
27.6 shall limit growth in the developmental
27.7 disability waiver to six diversion allocations
27.8 per month beginning July 1, 2011, through
27.9 June 30, 2013, and 15 diversion allocations
27.10 per month beginning July 1, 2013, through
27.11 June 30, 2015. Waiver allocations shall
27.12 be targeted to individuals who meet the
27.13 priorities for accessing waiver services
27.14 identified in Minnesota Statutes, 256B.092,
27.15 subdivision 12. The limits do not include
27.16 conversions from intermediate care facilities
27.17 for persons with developmental disabilities.
27.18 Notwithstanding any contrary provisions in
27.19 this article, this paragraph expires June 30,
27.20 2015.

27.21 **Limit Growth in the Community**
27.22 **Alternatives for Disabled Individuals**
27.23 **Waiver.** The commissioner shall limit
27.24 growth in the community alternatives for
27.25 disabled individuals waiver to 60 allocations
27.26 per month beginning July 1, 2011, through
27.27 June 30, 2013, and 85 allocations per
27.28 month beginning July 1, 2013, through
27.29 June 30, 2015. Waiver allocations must
27.30 be targeted to individuals who meet the
27.31 priorities for accessing waiver services
27.32 identified in Minnesota Statutes, section
27.33 256B.49, subdivision 11a. The limits include
27.34 conversions and diversions, unless the
27.35 commissioner has approved a plan to convert
27.36 funding due to the closure or downsizing

28.1 of a residential facility or nursing facility
28.2 to serve directly affected individuals on
28.3 the community alternatives for disabled
28.4 individuals waiver. Notwithstanding any
28.5 contrary provisions in this article, this
28.6 paragraph expires June 30, 2015.

28.7 ~~**Personal Care Assistance Relative**~~

28.8 ~~**Care.** The commissioner shall adjust the~~
28.9 ~~capitation payment rates for managed care~~
28.10 ~~organizations paid under Minnesota Statutes,~~
28.11 ~~section 256B.69, to reflect the rate reductions~~
28.12 ~~for personal care assistance provided by~~
28.13 ~~a relative pursuant to Minnesota Statutes,~~
28.14 ~~section 256B.0659, subdivision 11.~~

28.15	(h) Alternative Care Grants	46,421,000	46,035,000
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28.16 **Alternative Care Transfer.** Any money
28.17 allocated to the alternative care program that
28.18 is not spent for the purposes indicated does
28.19 not cancel but shall be transferred to the
28.20 medical assistance account.

28.21	(i) Chemical Dependency Entitlement Grants	94,675,000	93,298,000
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28.22 **EFFECTIVE DATE.** This section is effective July 1, 2012.

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

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

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

28.28 **ARTICLE 2**

28.29 **HEALTH AND HUMAN SERVICES APPROPRIATIONS**

28.30 Section 1. **SUMMARY OF APPROPRIATIONS.**

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

S.F. No. 2486, as introduced - 87th Legislative Session (2011-2012) [12-3996]

29.1			<u>2012</u>		<u>2013</u>		<u>Total</u>
29.2	<u>General</u>	\$	<u>1,284,000</u>	\$	<u>26,941,000</u>	\$	<u>28,225,000</u>
29.3	<u>State Government Special</u>						
29.4	<u>Revenue</u>		<u>-0-</u>		<u>638,000</u>		<u>638,000</u>
29.5	<u>Total</u>	<u>\$</u>	<u>1,284,000</u>	<u>\$</u>	<u>27,579,000</u>	<u>\$</u>	<u>28,863,000</u>

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

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

29.17			<u>APPROPRIATIONS</u>	
29.18			<u>Available for the Year</u>	
29.19			<u>Ending June 30</u>	
29.20			<u>2012</u>	<u>2013</u>

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

29.23 Subdivision 1. **Total Appropriation** **\$** **1,284,000** **\$** **27,016,000**

29.24	<u>Appropriations by Fund</u>			
29.25		<u>2012</u>		<u>2013</u>
29.26	<u>General</u>	<u>1,284,000</u>		<u>26,378,000</u>
29.27	<u>State Government</u>			
29.28	<u>Special Revenue</u>	<u>-0-</u>		<u>638,000</u>

29.29 **Subd. 2. Central Office Operations**

29.30 **(a) Operations**

29.31	<u>Appropriations by Fund</u>			
29.32		<u>2012</u>		<u>2013</u>
29.33	<u>General</u>	<u>107,000</u>		<u>6,000</u>
29.34	<u>State Government</u>			
29.35	<u>Special Revenue</u>	<u>-0-</u>		<u>638,000</u>

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

30.1	<u>Base Level Adjustment.</u> The general fund		
30.2	<u>base for health care is decreased by \$82,000</u>		
30.3	<u>in fiscal years 2014 and 2015.</u>		
30.4	<u>(c) Continuing Care</u>	<u>-0-</u>	<u>48,000</u>
30.5	<u>Base Level Adjustment.</u> The general fund		
30.6	<u>base for continuing care is decreased by</u>		
30.7	<u>\$152,000 in fiscal years 2014 and 2015.</u>		
30.8	<u>Subd. 3. Forecasted Programs</u>		
30.9	<u>Medical Assistance Grants</u>	<u>623,000</u>	<u>21,918,000</u>
30.10	<u>Subd. 4. Grant Programs</u>		
30.11	<u>(a) Children and Community Services Grants</u>	<u>-0-</u>	<u>542,000</u>
30.12	<u>White Earth Human Services Transfer</u>		
30.13	<u>Grant.</u> Of the general fund appropriation,		
30.14	<u>\$542,000 in fiscal year 2013 is for a grant to</u>		
30.15	<u>the White Earth tribe to support development</u>		
30.16	<u>of local capacity for effective and efficient</u>		
30.17	<u>delivery of human services to tribal members</u>		
30.18	<u>and their families. This appropriation is</u>		
30.19	<u>added to the base.</u>		
30.20	<u>(b) Aging and Adult Services Grants</u>	<u>-0-</u>	<u>999,000</u>
30.21	<u>Essential Community Support grants.</u>		
30.22	<u>This is a onetime appropriation in fiscal year</u>		
30.23	<u>2013 and does not affect the fiscal year 2014</u>		
30.24	<u>and 2015 base for these grants.</u>		
30.25	<u>(c) Disabilities Grants</u>	<u>-0-</u>	<u>250,000</u>
30.26	<u>Needs assessments.</u> This appropriation is		
30.27	<u>for the needs assessments under Minnesota</u>		
30.28	<u>Statutes, sections 245A.03, subdivision 7,</u>		
30.29	<u>and 256B.49, subdivision 15. This is a</u>		
30.30	<u>onetime appropriation.</u>		
30.31	<u>Subd. 5. State-Operated Services</u>		
30.32	<u>SOS Mental Health</u>	<u>549,000</u>	<u>2,713,000</u>

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

31.8 Sec. 4. **COMMISSIONER OF HEALTH** **\$** **0** **\$** **563,000**
31.9 **\$563,000 in fiscal year 2013 is to increase**
31.10 **inspection and oversight of licensed home**
31.11 **care providers under Minnesota Statutes,**
31.12 **chapter 144A. This appropriation is added**
31.13 **to the base.**

31.14 Sec. 5. **EXPIRATION OF UNCODIFIED LANGUAGE.**
31.15 **All uncodified language contained in this article expires on June 30, 2013, unless a**
31.16 **different expiration date is explicit.**

31.17 Sec. 6. **EFFECTIVE DATE.**
31.18 **The provisions in this article are effective July 1, 2012, unless a different effective**
31.19 **date is explicit.**

APPENDIX
Article locations in 12-3996

ARTICLE 1	HUMAN SERVICES	Page.Ln 1.13
ARTICLE 2	HEALTH AND HUMAN SERVICES APPROPRIATIONS	Page.Ln 28.28