HOUSE RESEARCH

Bill Summary

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Article 1: Appropriations

Overview

This article provides appropriations for the Departments of Health and Human Services for fiscal years 2008 and 2009. For additional information, see the Fiscal Analysis Department spreadsheet.

Article 2: Child Care

Overview

This article modifies the child care assistance program and creates school readiness service agreements.

1 Eligibility requirements for child care assistance. Amends § 119B.09, subd. 1. Modifies eligibility requirements for child care assistance by removing language referencing families receiving MFIP and who are participating in employment and training services. Adds language including families who have household income less than or equal to 250 percent of the federal poverty guidelines, adjusted for family size, and were a family whose child care assistance was terminated due to insufficient funds. Makes this section effective July 1, 2008.

2 Date of eligibility for assistance. Amends § 119B.09, subd. 7. Adds paragraph (c), which specifies that payment of child care assistance for participants eligible under the MFIP child care program may only be made retroactive for a maximum of six months from the date of application for child care assistance. Makes this section effective July 1, 2008.

3 Payment of other child care expenses. Amends § 119B.09, by adding subd. 11. Specifies that payment, by a source other than the family, of all or part of a family's child care assistance expenses not payable under the child care assistance program, does not affect the family's eligibility for child care assistance, and the amount paid is excluded from the family's income, if the funds are paid directly to the family's child care provider on behalf of the family. Requires child care providers who accept third party payments to maintain family-specific documentation of payment source, amount, type of expenses, and time period covered by the payment.

4 Provider payments. Amends § 119B.13, subd. 6. Modifies provider payments by requiring bills to be submitted within 60 days of the last date of service on the bill if the provider has received an authorization of care and been issued a billing form for an eligible family.

Adds paragraph (d), which limits retroactive payments to providers to six months from the date the provider is issued an authorization of care and billing form.

Makes technical changes.

5 School readiness service agreements.

Subd. 1. Overview. Paragraph (a) requires funds to be made available, effective July 1, 2007, to allow the commissioner to enter into school readiness service agreements (SRSAs) with up to 50 child care providers to support improved school readiness of

children and economic stability for parents.

Paragraph (b) allows providers to be paid a rate above the maximum reimbursement rate currently allowed if the provider has entered into an SRSA with the commissioner, a family using that provider receives child care assistance, the family using that provider meets certain criteria, and funding is available.

Subd. 2. Provider eligibility. Paragraph (a) requires providers to apply to the commissioner to be considered for an SRSA. Lists the eligibility criteria providers must meet in order to apply for an SRSA.

Paragraph (b) allows the commissioner to waive certain requirements under paragraph (a), if necessary, to achieve geographic distribution of SRSA providers and diversity of types of care provided by SRSA providers.

Paragraph (c) requires eligible providers who would like to enter into an SRSA with the commissioner to submit an SRSA application. Lists the factors the commissioner must evaluate in determining whether to enter into an SRSA with a provider.

Subd. 3. Family and child eligibility. Paragraph (a) lists eligibility criteria families must meet in order to choose an SRSA provider for their children.

Paragraph (b) makes families who are determined to be eligible to choose an SRSA provider eligible to be paid at a higher rate through the SRSA provider when certain specified conditions exist.

Paragraph (c) specifies that for the 12 months after initial eligibility has been determined, a decrease in the family's authorized activities to an average of less than 35 hours per week does not result in ineligibility for the SRSA rate.

Paragraph (d) requires that families that move between counties but continue to use the same SRSA provider continue to receive SRSA funding for the increased payments.

Subd. 4. Requirements of providers. Requires that all SRSAs include assessment, evaluation, and reporting requirements that promote the goals of improved school readiness and movement toward appropriate child development milestones. Requires providers who enter into an SRSA to comply with the assessment, evaluation, and reporting requirements in the SRSA.

Subd. 5. Relationship to current law. Lists provisions in current child care assistance statutes that must be waived or modified for families receiving SRSA services.

Subd. 6. Establishment of service agreements. Paragraph (a) requires the commissioner to approve SRSAs for up to 50 providers that represent diverse parts of the state and a variety of child care delivery models. Specifies that entering into an agreement does not guarantee that a provider will receive payment at a higher rate for

families receiving child care assistance. Requires families eligible for this program to choose a provider participating in an SRSA in order for a higher rate to be paid. Limits payments through SRSAs to the availability of funds.

Paragraph (b) specifies that nothing shall be construed to limit parent choice of providers.

Paragraph (c) allows the commissioner to allow for startup time for some providers if failing to do so would limit geographic diversity of SRSA providers or a variety of child care delivery models.

Article 3: Children and Family

Overview

This article modifies the MFIP program including changes required for compliance with the reauthorized federal TANF program.

1 Eligible participants. Amends § 119B.05, subd. 1. Adds a statutory reference to section 256J.09 (applying for assistance).

2 Immigration status verifications. Amends § 256.01, subd. 18. Adds a requirement that the commissioner use the federal Systematic Alien Verification for Entitlements program to conduct immigration status verifications for all MFIP and food assistance recipients at recertification, rather than just at the time of application. Removes obsolete language.

3 Commissioner's authority to administer block grant funds. Amends § 256J.02, subd. 1. Adds a reference to the federal Deficit Reduction Act of 2005.

4 Authority to transfer. Amends § 256J.02, subd. 4. Adds a reference to the federal Deficit Reduction Act of 2005.

5 Separate state program for use of state money. Amends § 256J.021. Modifies the use of state money in a separate state program in order to meet the new federal TANF maintenance of effort (MOE) requirements. Beginning October 1, 2007, requires the commissioner to treat MFIP expenditures made to or on behalf of any minor child who is part of a household that meets certain specified criteria as an expenditure under a separately funded state program.

Beginning March 1, 2008, requires the commissioner to treat MFIP expenditures made to or on behalf of any minor child who is part of a single eligible caregiver household that meets certain specified criteria as expenditures under a separately funded state program. Specifies that a household is no longer part of the separately funded program if the household no longer meets certain criteria.

The above expenditures do not count toward the state's MOE requirements under the federal TANF program.

6 Interview to determine referrals and services. Amends § 256J.09, subd. 3b. Modifies the duties a county agency must perform when an applicant meets the MFIP eligibility requirements. Makes this section effective July 1, 2008.

7 Employment plan; MFIP benefits. Amends § 256J.09, by adding subd. 11. Specifies the duties of the employment services provider in relation to the development of an initial

employment plan. Requires counties to issue MFIP benefits within one working day after receiving notice that the employment plan has been signed. Makes this section effective July 1, 2008.

8 Immediate referral to employment services. Amends § 256J.09, by adding subd. 12. Requires counties to refer all caregivers to employment services within one working day of a determination of MFIP eligibility. Lists the information the referral to employment services must contain in writing. Makes this section effective July 1, 2008.

9 Recertification. Amends § 256J.32, subd. 6. Modifies the list of information counties must verify when recertifying eligibility in an annual face-to-face interview with an MFIP participant.

10 Time limit. Amends § 256J.42, subd. 1. Clarifies that months during which any cash assistance is received by an assistance unit with a mandatory member who is disqualified for wrongly obtaining public assistance counts toward the time limit for the disqualified member. Makes this section effective October 1, 2007.

11 Case review. Amends § 256J.42, subd. 6. Removes obsolete language. Modifies county case reviews that are required before a participant's 60th month in relation to single caregiver households included in the separately funded non-MOE state program.

12 Simplified sanctions for extended cases. Amends § 256J.425, by adding subd. 9. Paragraph (a) creates new sanctions, beginning July 1, 2008, for participants in an assistance unit receiving MFIP assistance who are not in compliance with certain specified program requirements.

Paragraph (b) considers it one occurrence of noncompliance if both participants in a two-parent assistance unit are out of compliance at the same time.

Paragraph (c) specifies sanctions for two-parent assistance units that are extended under certain circumstances and a parent who has not reached the 60-month time limit is out of compliance with certain specified program requirements.

Paragraph (d) specifies sanctions for assistance units in which one or both participants in the assistance unit refuse to cooperate with child support enforcement.

Paragraphs (e) to (i) specify sanctions participants are subject to for refusal to comply with child support requirements and to a concurrent employment services sanction.

13 Status of disqualified participants under simplified sanctions. Amends § 256J.425, by adding subd. 10. Paragraphs (a) to (c) specify the status of disqualified participants who have been sanctioned for various types of noncompliance.

Paragraph (d) requires county agencies to review the participant's case to determine if the employment plan is still appropriate and attempt to meet with the participant face-to-face prior to a disqualification. Requires the county to send the participant a notice of adverse action if a face-to-face meeting is not conducted. Lists county responsibilities during the face-to-face meeting.

14 Simplified sanctions. Amends § 256J.46, by adding subd. 3. Paragraph (a), beginning July 1, 2008, subjects participants who fail without good cause to meet the MFIP requirements, who are not subject to other sanctions, to sanctions under this subdivision. Requires counties to provide a notice of intent to sanction and, when applicable, a notice of adverse

action.

Paragraph (b) specifies when sanctions under this subdivision become effective.

Paragraphs (c) to (e) specify how sanctions for noncompliance are imposed.

Paragraph (f) requires counties to close an MFIP assistance unit's financial assistance case for a fourth occurrence of noncompliance by a participant in an assistance unit, or when the participants in a two-parent assistance unit have a total of four occurrences of noncompliance. Before the case is closed, requires counties to attempt to meet face-to-face with participants to review the case to determine if the employment plan is still appropriate.

Paragraph (g) specifies the duties of counties during the face-to-face meeting.

Paragraph (h) specifies that only occurrences of noncompliance that occur after July 1, 2008, are considered for the purposes of applying sanctions under this subdivision.

Paragraph (i) allows an assistance unit whose case has been closed under paragraph (f) or (j) to reapply for MFIP and makes them eligible for MFIP if the participant complies with MFIP program requirements and demonstrates compliance for up to one month. Prohibits payment of assistance during this period.

Paragraph (j) subjects an assistance unit whose case has been closed for noncompliance that reapplies under paragraph (i) to sanctions under paragraph (e) for a first occurrence of noncompliance. Requires case closure for any subsequent occurrence of noncompliance.

15 Simplified sanctions for refusal to cooperate with support requirements. Amends § 256J.46, by adding subd. 4. Beginning July 1, 2008, subjects MFIP caregivers who refuse to cooperate with child support requirements to a sanction. Specifies how sanctions are applied.

16 Simplified dual sanctions. Amends § 256J.46, by adding subd. 5. Beginning July 1, 2008, specifies how sanctions are applied when a participant is noncompliant with more than one program requirement at the same time.

17 Work activity. Amends § 256J.49, subd. 13. Modifies the definition of "work activity."

18 Employment and training services component of MFIP. Amends § 256J.50, subd. 1. Removes obsolete language. Effective July 1, 2008, requires counties to provide employment and training services within ten days, rather than 30 days, after the caregiver is determined eligible for MFIP.

19 Employment plan; nonmaintenance of effort; single caregivers. Amends § 256J.521, by adding subd. 6. Paragraph (a) requires single caregivers to develop or revise their employment plan with a job counselor or county when the single caregiver is moved to the nonmaintenance of effort state-funded program. Specifies plan requirements.

Paragraph (b) requires counties to coordinate services by ensuring that all workers involved with the family communicate on a regular basis, and that expectations for the family across service areas lead to common goals.

Paragraph (c) allows activities and hourly requirements in the employment plan to be adjusted as necessary to accommodate personal and family circumstances of the participant.

Requires participants who no longer meet the criteria for the non-MOE of effort state-funded program to meet with the job counselor or county within 10 days of the determination to revise the employment plan.

20 Basic education; English as a second language. Amends § 256J.531.

Subd. 1. Approval of adult basic education. Removes language limiting the amount of time participants may attend adult basic education or general education development classes.

Subd. 2. Approval of English as a second language. Removes language limiting the amount of time participants may attend ESL or functional work literacy classes.

Makes this section effective October 1, 2007.

21 Performance base funds. Amends § 256J.626, subd. 7. Modifies the allocation of additional funds to counties and tribes based on performance.

22 Specialized employment. Amends § 256J.626, by adding subd. 10. Beginning July 1, 2007, requires the commissioner to make funds available annually to counties and tribes to develop paid and unpaid work experience positions for MFIP participants with no recent work history. Requires the commissioner to develop a process for approving requests and allocating funding in consultation with the counties and tribes.

23 Community service work experience. Creates § 256J.675.

Subd. 1. Employment options. Limits community service work experience positions to projects that serve a useful public service such as health care, social service, environmental protection, education, urban and rural development and redevelopment, welfare, recreation, public facilities, public safety, community service, services to aged or disabled citizens, and child care. To the extent possible, requires consideration of the prior training, skills, and experience of the participant in making appropriate work experience assignments.

Subd. 2. Placing participants in community service work experience. Lists conditions the counties must meet in placing participants in a community service work experience program.

24 Injury protection for community service work experience participants. Creates § 256J.678.

Subd. 1. Authority. Requires the Department of Administration, in consultation with the Department of Human Services, to contract with an approved insurance carrier to provide coverage for injuries or death resulting from a person's participation in paid and unpaid community work experience programs.

Subd. 2. Claims. Requires claims to be reported to the insurance carrier in a format approved by the carrier and by the department of the state, county, or tribal program responsible for supervising the work.

Subd. 3. Exclusive procedure. Makes exclusive the procedure established by this section of all other legal, equitable, and statutory remedies against the state, employees of the state, or the state's political subdivisions. Prohibits the claimant from seeking damages from any other state, county, tribal, or reservation insurance

policy or self-insurance program.

Subd. 4. Requirements for worksites. Requires departments of the state, counties, or tribal programs responsible for supervising the work to ensure that no participant is assigned to a worksite that is in violation of federal OSHA and state Department of Labor and Industry safety standards or is under investigation to determine if those violations have occurred. Requires all participants to be given the same safety information and training given to a paid employee performing similar work at that worksite.

25 Quarterly comparison report. Amends § 256J.751, subd. 2. Updates a federal statutory reference.

26 Failure to meet federal performance standards. Amends § 256J.751, subd. 5. Adds a reference to the federal Deficit Reduction Act of 2005. Makes technical changes.

27 Limitations on certain work activities. Amends § 256J.95, subd. 15. Modifies limitations on certain work activities, including ESL and functional work literacy.

28 Repealer. Paragraph (a) repeals §§ 256J.67 (community work experience) and 256J.68 (injury protection for work experience participants), effective June 30, 2007.

Paragraph (b) repeals §§ 256J.425, subdivisions 6 and 7 (sanctions for extended cases and status of disqualified participants) and 256J.46, subdivisions 1, 2, and 2a (participants not complying with program requirements, sanctions for refusal to cooperate with support requirements, and dual sanctions), effective June 30, 2008.

Paragraph (c) repeals § 256J.29 (ineligibility for state-funded programs).

Article 4: Licensing

Overview

This article brings state law into conformity with the federal Adam Walsh Child Protection and Safety Act of 2006, Public Law 109-248. The federal law requires, among other things, that criminal record checks include fingerprint checks for any foster or adoptive parent in national crime databases before a child can be placed in the home. The law mandates that before a child is placed, any prospective foster or adoptive parent must be checked through the state's child abuse registry, if one exists, and any other state registry where the parent has resided within the past five years. This article also assesses a fee of no more than $20 for a background study initiated by temporary personnel agencies, educational programs, and professional service agencies.

1 Unlicensed emergency relative placement. Amends § 245A.035 and its head note.

Subd. 1. Emergency placement. Allows a county agency to make the emergency placement of a child with a relative who is not licensed to provide foster care if the requirements of this section are met.

Subd. 2. Cooperation with emergency placement process. Strikes language regarding

securing and issuing an emergency foster care license.

Subd. 3. Requirements for emergency placement. Strikes the words "license" and "foster care" and inserts the word "placement."

Subd. 4. Applicant study. Strikes language regarding emergency foster care licenses.

Subd. 5. Child foster care license application. Continues the requirement that relatives complete an application for a foster care license within 10 days of the child's emergency placement. Requires the commissioner of human services to provide written notice to the relative if a background study shows the relative is disqualified under section 245C.14.

Subd. 6. Denial of emergency license. This subdivision is stricken.

2 Delegation of authority to agencies. Amends § 245A.16, subd. 1. Because the commissioner will be conducting background studies for all prospective foster and adoptive parents, clarifies the role of county agencies in reporting requirements and performing background studies for adult foster care, family adult day services, and family child care.

3 Recommendations to the commissioner. Amends § 245A.16, subd. 3. Specifies that county and private agencies are responsible for background studies for adult foster care, family adult day services, and family child care.

4 Private agency. Amends § 245C.02, by adding subd. 14a. Adds the definition of "private agency" to the background studies chapter.

5 Licensed programs. Amends § 245C.02, subd. 1.

- Adds family adult day services to programs on which the commissioner must conduct a background study at the time of reapplication for licensure.

- Adds paragraph (d) that requires the commissioner to conduct a background study of persons reapplying for child foster care licensure from July 1, 2007, to June 30, 2009. Sets out the specific information the county or private agency must submit to the commissioner so that the background study can be completed.

- Adds paragraph (e) that requires the commissioner to conduct a background study of specified individuals who are newly affiliated with a child foster care license holder.

6 Individual studied. Amends § 245C.05, subd. 1. Requires that when a background study for child foster care is requested by a private agency, a background study subject must sign a release of information so that the commissioner can release any information from the national crime information data base to the private agency. Requires that the subject provide a set of classifiable fingerprints obtained from an authorized agency.

7 County or private agency. Amends § 245C.05, by adding subd. 2a. Provides that for background studies related to child foster care, county and private agencies must collect information under subdivision 1 and forward it to the commissioner. This information includes: demographics, Minnesota driver's license number, address of residence for the past five years, and a set of classifiable fingerprints.

8 Electronic transmission. Amends § 245C.05, subd. 4. Instructs the commissioner to use an

electronic transmission system to send background study results to county and private agencies for background studies conducted for child foster care.

9 Fingerprints. Amends § 245C.05, subd. 5. Requires applicants for child foster care licensure to provide the commissioner with a set of classifiable fingerprints obtained from an authorized agency.

10 Probation officer and corrections agent. Amends § 245C.05, subd. 7. Provides that a probation officer or corrections agent must notify the commissioner of an individual's conviction of a crime constituting disqualification under section 245C.14, if the individual is affiliated with child foster care.

11 Background studies conducted by commissioner of human services. Amends § 245C.08, subdivision 1. Requires the commissioner to obtain and review information from the child abuse registry for any state in which the background study subject has resided over the past five years and information from national crime information databases on any applicant for child foster care licensure.

12 Background studies conducted by a county agency. Amends § 245C.08, subd. 2. Because the commissioner will be performing background studies on all prospective foster parents, changes in this section clarify the role of county agencies in background studies on adult foster care, family adult day services, and family child care homes.

13 Temporary personnel agencies, educational programs, and professional services agencies. Amends § 245C.10, by adding subd. 4. Allows the commissioner to recover up to a $20 fee from these agencies to offset the cost of background studies. Supplemental nursing service agencies and personal care provider organizations also pay up to a $20 fee to offset the cost background studies.

14 Adult foster care; criminal conviction data. Amends § 245C.11, subd. 1. Clarifies that this subdivision applies to adult foster care programs.

15 Jointly licensed programs. Amends § 245C.11, subd. 2. Clarifies that this subdivision applies to adult foster care programs.

16 Background study; tribal organizations. Amends § 245C.12. Allows tribal organizations to contract with the commissioner to obtain background study data on individuals under tribal jurisdiction related to adoptions or child foster care according to section 245C.34. A description of this new statute is found in section 0.

17 Determining immediate risk of harm. Amends § 245C.16, subd. 1. Specifies that this section does not apply to a background study related to an initial application for a child foster care license.

18 Notice to county or private agency. Amends § 245C.17, by adding subd. 5. Instructs the commissioner to provide a notice of the background study results to the county or private agency that initiated the study on an individual who applied for a child foster care license.

19 Submission of reconsideration request to county or private agency. Amends § 245C.21, by adding subd. 1a. Provides that if an individual has been disqualified, the request for reconsideration is to be submitted to the county or private agency that initiated the background study. Instructs the county or private agency to forward the individual's request for reconsideration to the commissioner along with a recommendation whether to set aside the disqualification.

20 Commissioner's notice of disqualification that is not set aside. Amends § 245C.23, subd. 2. Requires the commissioner to notify the county or private agency that initiated the child foster care background study of the results of reconsideration.

21 Adoption background study requirements. Adds § 245C.33.

Subd. 1. Background studies conducted by the commissioner. Provides that before any child is placed for adoption, the commissioner must conduct a background study for county and private agencies licensed to place children for adoption.

Subd. 2. Information and data provided to county or private agency. Requires the background study subjects to provide the county or private agency with all of the information required in 245C.05; a set of classifiable fingerprints; and for private agencies, a signed release of information for information received from national crime information databases to the private agency.

Subd. 3. Information and data provided to commissioner. Instructs the county or private agency to forward all the data to the commissioner.

Subd. 4. Information commissioner reviews. Lists the information the commissioner must review. States that the commissioner shall provide this information to the county or private agency that initiated the background study and shall indicate whether the individual has one of the criminal convictions specified in federal law.

22 Adoption and child foster care background studies; tribal organizations. Adds § 245C.34.

Subd. 1. Background studies may be conducted by the commissioner. Allows tribal organizations to contract with the commissioner to obtain background study data on individuals under tribal jurisdiction related to adoption or child foster care. Requires that background studies initiated by a tribal organization conform to the provisions of subdivisions 2 and 3.

Subd. 2. Information and data provided to tribal organization. Requires the background study subjects to provide the tribal organization with all of the information required in 245C.05; a set of classifiable fingerprints; and a signed release of information for information received from national crime information databases to the tribal organization.

Subd. 3. Information and data provided to the commissioner. Instructs the tribal organization to forward all the data to the commissioner.

Subd. 4. Information commissioner reviews. Lists the information the commissioner must review. States that the commissioner shall provide this information to the tribal organization that initiated the background study and shall indicate whether the individual has one of the criminal convictions specified in federal law.

23 Other applicable law. Amends § 259.20, subd. 2. Specifies that in conformity with state and federal law a completed background study is required before the approval of any foster or adoptive placement in a related or unrelated home.

24 Best interests of the child. Amends § 259.29, subd. 1. Specifies that in conformity with state and federal law a completed background study is required before the approval of any foster or adoptive placement in a related or unrelated home.

25 Adoption study. Amends § 259.41.

Subd. 1. Study required before placement; certain relatives excepted. Adds that an approved adoption study and a background study must be completed before a child is

placed in a prospective adoptive home.

Subd. 2. Form of study. Lists the components that must be documented in the adoption study.

Subd. 3. Background study. Specifies that in conformity with state and federal law a completed background study is required before the approval of any foster or adoptive placement in a related or unrelated home. Lists the convictions that would prevent child placement.

26 Preadoptive custody order. Amends § 259.47, subd. 3. Specifies that in conformity with state and federal law a completed background study is required before the approval of any foster or adoptive placement in a related or unrelated home.

27 Adoption agencies; postplacement assessment and report. Amends § 259.53, subd. 2. Clarifies that individuals related to the child are required to have a completed background study in compliance with federal law.

28 Protection of child's best interest. Amends § 259.57, subd. 2. Specifies that in conformity with state and federal law a completed background study is required before the approval of any foster or adoptive placement in a related or unrelated home.

29 Best interest of the child in foster care or residential care. Amends § 260C.193, subd. 3. Specifies that in conformity with state and federal law a completed background study is required before the approval of any foster or adoptive placement in a related or unrelated home.

30 Background checks. Amends § 260C.209.

Subd. 1. Clarifies that the responsible social services agency initiates a background study to be completed by the commissioner.

Subd. 2. Specifies that in conformity with state and federal law a completed background study is required before the approval of any foster or adoptive placement in a related or unrelated home.

Subd. 3. Specifies that the subject of the background study must submit a set of classifiable fingerprints that will be used by the commissioner to obtain criminal history data from national crime information databases.

Subd. 4. Notice upon receipt. Requires the commissioner to notify the subject of the background study of the results of the study.

31 Placement decision based on best interest of the child. Amends § 260C.212, subd. 2. Specifies that in conformity with state and federal law a completed background study is required before the approval of any foster or adoptive placement in a related or unrelated home.

Article 5: Health Care

Overview

This article contains provisions related to health care access fund transfers, the council on disability, and state health care program reimbursement.

1 Transfers. Amends § 16A.724, subd. 2. For the biennium ending June 30, 2009, limits the amount of money that can be transferred from the health care access fund to the general fund to $126,583,000.

2 Establishment; members. Amends § 256.483, subd. 1. Provides that the expiration dates that govern advisory councils do not apply to the council on disability, since the council performs functions that are not purely advisory.

3 Sunset. Amends § 256.482, subd. 8. Strikes language that provides that the council on disability does not sunset until June 30, 2007.

4 Access to medical services. Amends § 256B.0625, subd. 18a. Sets MA mileage reimbursement at 15 cents below the level at which the Internal Revenue Service reimburses mileage for business purposes.

5 Physician and dental reimbursement. Amends § 256B.76. For dental services provided after June 30, 2007, sets MA reimbursement for critical access dental providers at 33 percent above the rate that would otherwise be paid. Strikes language that allows reimbursement, within the limits of the available appropriation, to be increased to 50 percent above the rate that would otherwise be paid. Also strikes language requiring the commissioner to establish a reimbursement schedule and provider specific limits for critical access dental providers, and to notify providers of this schedule and limits.

6 Critical access dental providers. Amends § 256L.11, subd. 7. Effective July 1, 2007, sets the MinnesotaCare critical access dental reimbursement rate at 33 percent above the rate that would otherwise be paid. Limits the current rate of 50 percent above the rate that would otherwise be paid to the period January 1, 2007, to June 30, 2007.

Article 6: Continuing Care

Overview

This article makes changes to licensure requirements for home and community-based waiver services providers, modifies family support grants, modifies deaf-blind service funding, and provides COLA increases for certain providers.

1 Adult. Amends § 245A.02, subd. 2. Modifies the definition of "adult" to include persons who are 18 years old and older and who have a chronic health condition.

2 Nonresidential program. Amends § 245A.02, subd. 10. Modifies the list of programs included in the definition of "nonresidential program."

3 Residential program. Amends § 245A.02, subd. 14. Modifies the definition of "residential program" by removing certain programs from the definition.

4 Application fee for initial license or certification. Amends § 245A.10, subd. 3. Modifies the list of programs that do not have to be provided at a specific location.

5 License or certification fee for certain programs. Amends § 245A.10, subd. 4. Requires adult day supports and habilitation programs under a federally approved home and

community-based services Medicaid waiver to be licensed under services for developmental disabilities statutes.

6 License or certification fee for other programs. Amends § 245A.10, subd. 5. Makes technical and conforming changes.

7 Purpose. Amends § 245B.01. Provides for the purpose of Minnesota Statutes, chapter 245B, including establishing provider standards for the health, safety, and protection of rights for people with disabilities receiving services and supports licensed by the commissioner of human services. Provides a method for the commissioner to meet federal requirements for the Medicaid home and community-based waivers for people with disabilities. Lists the federal requirements.

8 Definitions. Amends § 245B.02. Defines "adult day supports and habilitation," "crisis respite," "home and community-based disability waivers," and "restraints and restrictive interventions use standards." Modifies the definitions of "case manager," "consumer," "direct service," "individual service plan," "psychotropic medication use checklist," and "residential-based supports and habilitation."

9 Applicability. Amends § 245B.03, subd. 1. Modifies the list of services to which this chapter applies.

10 Relationship to other standards governing services. Amends § 245B.03, subd. 2. Makes technical changes. Adds paragraph (e), which subjects certain license holders who provide specified services at the same location only to the licensure requirements as an adult day habilitation and support service provider. Exempts certain other providers from licensure.

Adds paragraph (j), which allows the commissioner to approve alternative methods of meeting certain requirements for home and community-based waiver services programs that become subject to licensing standards on July 1, 2008, using the process and criteria for granting a variance.

11 Licensed capacity for facility-based adult day supports and habilitation services. Amends § 245B.05, subd. 2. Makes technical changes.

12 Scope. Amends § 245B.055, subd. 1. Modifies the scope to apply to license holders that provide day training and habilitation services to people with developmental disabilities.

13 Staffing requirements. Amends § 245B.06, subd. 7. Specifies day training and habilitation programs for people with developmental disabilities must meet certain minimum staffing requirements.

14 Day training and habilitation service days. Amends § 245B.06, subd. 9. Specifies that day training and habilitation services for people with developmental disabilities must meet a minimum of 195 available service days.

15 Prohibition. Amends § 245B.06, subd. 10. Prohibits the use of restraints and restrictive interventions as a substitute for adequate staffing.

16 Use of restraints and restrictive interventions. Amends § 245B.06, by adding subd. 11. Requires license holders to follow the restraints and restrictive interventions standards if implementing restraint or restrictive interventions for nondevelopmentally disabled consumers who are not protected by certain standards and rules.

17 Staff qualifications. Amends § 245B.07, subd. 4. Broadens the prior work experience allowed to include work or educational experience with all persons with disabilities rather than only persons with developmental disabilities. Includes as qualified staff persons with two years of work experience, which includes certain minimum criteria, with consumers with disabilities. Makes technical changes.

18 Policies and procedures. Amends § 245B.07, subd. 8. Specifies that the commissioner will

provide license holders with the psychotropic medication use checklist.

19 Amount of support grant; use. Amends § 252.32, subd. 3. Adds language to the family support grant program maximum grant amount allowing for any legislatively authorized cost of living adjustments.

20 Consumer information and assistance; senior linkage. Amends § 256.975, subd. 7. Requires the Senior LinkAge Line to incorporate information about housing with services and consumer rights within the MinnesotaHelp.info network long-term care data base to facilitate consumer comparison of services and costs. Specifies the procedures to be followed by providers and the commissioner in making this data available. Provides an effective date of the day following final enactment.

21 Access to medical services. Amends § 256B.0625, subd. 18a. Provides that MA covers sign language interpreter services, regardless of the number of employees a health care provider has. (Under current procedure, providers with 15 or more employees must pay for sign language interpretation, while the county human services agency pays for services if a provider has fewer than 15 employees.)

22 Transition to housing with services. Amends § 256B.0911, by adding subd. 3c. (a) Requires all prospective residents of housing with services establishments 65 years of age or older to participate in transitional long-term care consultation. States that the purpose of transitional long-term care consultation is to assist people in making informed choices among options that include the most cost-effective and least restrictive settings, and to delay spending-down to public program eligibility.

(b) Requires the consultation services to be provided as determined by the commissioner in partnership with county long-term care consultation units and the Area Agencies on Aging, as a combination of telephone-based and in-person assistance. Requires the service to be provided within five working days of the request and meet specified criteria.

Provides an effective date of October 1, 2008.

23 Service rate limits; 24-hour customized living services. Amends § 256B.0915, by adding subd. 3h. Specifies the criteria and procedures for setting payment rates for 24-hour customized living services. States that the payment rate is a monthly rate negotiated and authorized by the lead agency within parameters set by the commissioner. Defines 24-hour supervision. Specifies that individually negotiated 24-hour customized living payments, in combination with payment for other elderly waiver services including case management, must not exceed the recipient's community budget cap.

24 Nursing facility rate increases beginning October 1, 2007, and October 1, 2008. Amends § 256B.434, by adding subd. 19. For the rate years beginning October 1, 2007, and October 1, 2008, requires the commissioner to make available to nursing facilities operating payment rate adjustments of up to 1.5 percent.

25 Development and implementation of quality profiles. Amends § 256B.439, subd. 1. Beginning July 1, 2008, requires the commissioners of human services and health to include quality profiles of nursing facilities that are not MA certified in the Minnesota Nursing Home Report Card. States that non-certified facilities may provide to the commissioners information necessary to conduct consumer satisfaction surveys and to determine other quality measures.

26 Calculation of quality add-on for October 1, 2007, and October 1, 2008. Amends § 256B.441, by adding subd. 46a. Provides that the maximum quality add-on for the rate years beginning October 1, 2007, and October 1, 2008, is 1.2 percent of the operating

payment rate. States that the quality add-on is based on each facility's quality score and specifies the methodology for calculating the add-on.

27 ICF/MR rate increases beginning October 1, 2007, and July 1, 2008. Amends § 256B.5012, by adding subd. 7. For the rate year beginning October 1, 2007, requires the commissioner to make available to each ICF/MR an operating payment rate adjustment of up to 2 percent. For the rate year beginning July 1, 2008, requires the commissioner to make available to each ICF/MR an operating payment rate adjustment of up to 2 percent.

28 Services for deaf-blind persons. Creates § 256C.261. Paragraph (a) requires the commissioner to combine the existing biennial base level funding for deaf-blind services into a single grant program. Specifies how grants will be awarded and for what purpose.

Paragraph (b) allows the commissioner to make grants for services and training provided by organizations and to develop and administer consumer-directed services.

Paragraph (c) specifies who is eligible for a grant.

Paragraph (d) allows deaf-blind service providers to provide intervenor services as part of the service package provided with grant funds.

29 General assistance medical care; services. Amends § 256D.03, subd. 4. Provides GAMC coverage for sign language interpreter services, regardless of the number of employees an enrolled health care provider may have.

30 Housing with services and home care providers study; report. Requires the commissioner of human services to study housing with services establishments and their arranged home care providers to assess the impact that residents spending down to become eligible for public programs has on public expenditures. Requires the commissioner to report preliminary results to the legislative committees with jurisdiction over health and human services policy and finance by February 15, 2008, and a final report by December 15, 2008. Requires housing with services establishments and home care providers to provide specified information to the commissioner. Provides an effective date of the day following final enactment.

31 Community services provider rate increases. Requires the commissioner of human services to increase reimbursement rates or rate limits by 2 percent for the rate periods beginning October 1, 2007, and October 1, 2008, for specified community-based providers.

Article 7: Health Insurance

Overview

This article expands MA and MinnesotaCare eligibility for children, reduces MinnesotaCare sliding scale premiums for children, and makes other changes related to state health care programs.

1 Performance payments. Amends § 256.01, subd. 2b. Allows the commissioner to receive any federal match made available through MA for managed care oversight, for purposes of the pay-for-performance system for medical groups serving persons with chronic diseases.

2 Children under age two. Amends § 256B.057, subd. 8. Allows MA to be paid for children under age two with incomes above 275 percent of FPG but not exceeding 305 percent of FPG (the limit under current law is 280 percent of FPG). Provides an effective date of

January 1, 2009, or upon federal approval, whichever is later. Requires the commissioner to notify the Revisor when federal approval is obtained.

3 Physician-directed care coordination services. Amends § 256B.0625, by adding subd. 49. Requires the commissioner to develop and implement a physician-directed care coordination program for MA recipients receiving services under fee-for-service. Requires the program to pay primary care clinics for care coordination for persons who have complex and chronic medical conditions. Specifies clinic criteria.

4 Families with children. Amends § 256L.04, subd. 1. Increases the MinnesotaCare income limit for children from 275 percent to 300 percent of FPG. Provides an effective date of January 1, 2009, or upon federal approval, whichever is later. Requires the commissioner to notify the Revisor when federal approval is obtained.

5 Commissioner's duties and payment. Amends § 256L.06, subd. 3. Eliminates the requirement that the commissioner develop and implement procedures to adjust MinnesotaCare premiums at the time a change in income is reported, and instead requires adjustment at the time of eligibility renewal. Provides an effective date of January 1, 2009, or upon federal approval, whichever is later. Requires the commissioner to notify the Revisor when federal approval is obtained.

6 Sliding fee scale; monthly gross income or family income. Amends § 256L.15, subd. 2. The amendment to paragraph (a) requires premiums to be adjusted at the time of eligibility renewal, rather than at the time a change in income is reported.

A new paragraph (b) establishes, beginning January 1, 2009, a new sliding fee scale premium schedule for children that begins with a premium of $11 per child for households with incomes not exceeding 150 percent of FPG and proceeds at increments of 5 percent of FPG to a maximum premium of $88 per child for households with incomes not exceeding 300 percent of FPG. Requires premiums to be calculated for up to three children per family, and requires premiums to be adjusted in proportion to the annual adjustment in premiums for adults. States that this sliding fee scale does not apply to children enrolled under section 256L.075 (the MinnesotaCare II option).

A re-lettered paragraph (c) requires children in families with incomes that exceed 300 percent of FPG to pay the maximum premium.

Strikes language in paragraph (c) of current law requiring an 8 percent increase in MinnesotaCare premiums.

Provides that paragraphs (a) and (b) are effective January 1, 2009, or upon federal approval, whichever is later. Requires the commissioner to notify the Revisor when federal approval is obtained. Provides that paragraph (c) is effective July 1, 2007.

Article 8: Mental Health

Overview

This article reforms the mental health service delivery and finance system.

1 Other professionals. Amends § 148C.11, subd 1. Allows city, county, or state employees to provide assessments without licensure as an alcohol and drug counselor until July 1, 2009.

Current law allows them to perform this function without licensure until July 1, 2007.

2 Responsibility not duplicated. Amends § 245.465 by adding subd. 3. Provides that the county board is not responsible for providing mental health services for an individual who has health insurance that covers the services.

3 Mental health service delivery and finance reform. Adds § 245.4682.

Subd. 1. Policy. States that the commissioner of human services shall reform Minnesota's mental health system. The goal is to improve availability, quality and accountability of mental health care in the state.

Subd. 2. General provisions. Paragraph (a). Instructs the commissioner of human services to:

- consult with stakeholders;
- make recommendations to the legislature and the state Mental Health Advisory Council by January 15, 2008, regarding the role of counties and to clarify case management roles and functions of counties and health plans;
- ensure continuity of care including client choice of provider;
- provide accountability for use of public and private resources in achieving positive outcomes for consumers;
- ensure client access to protections and appeals; and
- make budget transfers that do not increase the state and county costs and efficiently allocate state funds.

Paragraph (b). Provides that the commissioner, in consultation with the counties, shall ensure that any transfer of state grants to health care programs, including the value of case management, does not exceed the value of services for the latest 12-month period for which data is available. Allows the commissioner to make quarterly adjustments as needed during the first four quarters after the transfer occurs. Provides that if case management grants are repealed and the value exceeds the value of services being transferred, then the difference becomes an ongoing part of each county's adult and children's mental health grants.

Subd. 3. Projects for coordination of care. Paragraph (a). Authorizes the commissioner to solicit, approve, and implement demonstration projects to integrate physical and mental health services within prepaid health plans and their coordination with social services. Specifies components of the locally defined partnerships eligible for consideration as demonstration projects.

Paragraph (b). Instructs the commissioner to consult with consumers, families, and their representatives to:

- determine criteria for approving projects, then use the criteria to solicit proposals for preferred integrated networks;

- determine specifications for contracts with prepaid health plans;

- begin implementation no earlier than January 1, 2009, with no more than 40 percent of the population described in paragraph (c) during 2009, with additional individuals included in subsequent years;

- waive any administrative rule inconsistent with implementation of the project; and

- allow potential bidders at least 90 days to respond to the request for proposals.

Paragraph (c). Provides that the commissioner may enroll all individuals with serious mental illness or emotional disturbance who are eligible for medical assistance in the prepaid plan of their choice within the project service area unless the individual is eligible for home and community-based services, or has a basis for exclusion under section 256B.69, subdivision 4, other than disability, mental illness, or emotional disturbance.

Paragraph (d). States that the commissioner may assign an individual described in paragraph (c) to a prepaid participating plan, if the individual does not elect to stay in fee-for-service medical assistance or refuses to choose a plan.

Paragraph (e). Allows an individual in a prepaid plan under paragraph (c) to request to disenroll at any time.

Paragraph (f). Instructs the commissioner, in consultation with consumers, families, and their representatives to evaluate the projects implemented in 2009 and refine the design before enrolling more individuals and before expanding the number of service areas.

Paragraph (g). Instructs the commissioner to apply for any necessary federal waivers.

4 Duties of the county board. Amends § 245.4874 by adding subd. 2. Provides that a county board is not responsible for providing mental health services to an individual who has health insurance coverage for the services.

5 Children's mental health grants. Adds §245.4889.

Subd. 1. Establishment and authority. Authorizes the commissioner to make grants from available appropriations to counties, Indian tribes; children's collaboratives under section 124D.23 or 245.493; or mental health service providers who provide services to children with emotional disturbance or transition services to young adults. Services must be designed to help the child or young adult function in the community.

Subd. 2. Grant application and reporting requirements. Requires applicants to submit, in the form specified by the commissioner, an application and budget. Grantees must be approved by the commissioner. Instructs the commissioner to give priority to applicants that indicate plans to collaborate with other agencies in the local system of care. Requires the commissioner to specify requirements for reports, including quarterly fiscal reports and reports necessary to measure program effectiveness.

6 County portion for cost of care. Amends § 246.54, subd. 1. Sets the following schedule for county reimbursement to the state of the cost of a county resident's care at a regional treatment center:

- zero percent for the first 30 days;
- 20 percent for days 31 to 60; and
- 50 percent for any days over 60.

Provides that if the state receives payment under sections 246.50 to 246.53 that exceeds 80 percent of the cost of care for days 31 to 60, or 50 percent for days over 60, the county shall be responsible for paying the state only the remaining amount.

Under current law, counties pay a 20 percent share of cost.

States that this section is effective January 1, 2008.

7 Intensive mental health outpatient treatment. Amends § 256B.0625, by adding subd. 51. Provides that medical assistance covers intensive mental health outpatient treatment for dialectical behavioral therapy for adults. Instructs the commissioner to establish certification procedures for providers and treatment protocols.

States that this section is effective July 1, 2008, subject to federal approval.

8 Mental health case management. Amends § 256B.0625, subd. 20. Adds that prepaid medical assistance, GAMC, and MinnesotaCare include mental health case management. States that when provided through prepaid capitation, the nonfederal share is paid by the state and the county pays no share. Provides that when mental health case management service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility. Deletes obsolete language.

9 Required preservice and continuing education. Amends § 256B.0943, subd. 8. Provides that the commissioner must approve curricula for parent team training.

10 Payment rates. Amends § 256B.0945, subd. 4. Provides that the per diem rate paid to providers by prepaid plans shall be the proportion of the per-day contract rate for rehabilitative mental health services and shall not include payment for group foster care costs or services that are billed to the county of responsibility.

This section is effective January 1, 2009.

11 Limitation of choice. Amends § 256B.69, subd. 4. Allows the commissioner to enroll children with severe emotional disturbance, in a preferred integrated network under section 245.4682 (section 3 of this bill). Allows this group to decline participation in locations where there is no preferred integrated network.

This section is effective January 1, 2009.

12 Payment for covered services. Amends § 256B.69, subd. 5g. Excludes mental health services added as covered benefits after December 31, 2007, from the payment reduction to managed care plans.

13 Payment reduction. Amends § 256B.69, subd. 5h. Excludes mental health services added as covered benefits after December 31, 2007, from the payment reduction to managed care plans.

14 Critical access mental health rate increase. Amends § 256B.763. Adds paragraph (e) which states that rates shall be increased by 23.7 percent over the rates in effect on January 1, 2006 for medication education services provided by certified adult rehabilitative mental health providers and for mental health behavioral services provided by certified children's therapeutic services and support providers.

Adds paragraph (f) which states that rates shall be increased by 23.7 percent for services listed in paragraph (b) provided by certified children's therapeutic services and support providers that were not included in the payment rate increase already included by paragraph (a).

This section is effective January 1, 2008.

15 General assistance medical care; services. Amends § 256D.03, subd. 4. Adds mental health services covered by medical assistance as a benefit set for individuals who receive GAMC. Adds that payments for mental health services added as covered benefits are not subject to the payment reductions in paragraphs (i), (k), (l), and (m).

This section is effective January 1, 2008, except mental health case management under paragraph (a)(i)(15) is effective January 1, 2009.

16 Covered health services. Amends § 256L.03, subd. 1. Adds mental health services covered by medical assistance as a benefit set for individuals who receive MinnesotaCare.

This section is effective January 1, 2008, except mental health case management under subdivision 1 is effective January 1, 2009.

17 Limited benefits coverage for certain single adults and households without children. Amends § 256L.035. Adds mental health services covered by medical assistance as a benefit set for individuals who receive MinnesotaCare.

This section is effective January 1, 2008, except mental health case management under paragraph (a)(3) is effective January 1, 2009.

18 Rate setting; ratable reduction. Amends § 256L.12, subd. 9a. Excludes payments for mental health services added as covered benefits after December 31, 2007, from the payment reduction to managed care plans under MinnesotaCare.

19 Compulsive gambling assessment required. Amends § 609.115, subd. 9. Provides that the assessor must be qualified under either Minnesota Rules, part 9585.0040, subpart 1, item C, or qualifications determined to be equivalent by the commissioner. Deletes the maximum amount of $100 that the commissioner will reimburse the assessor for each assessment.

20 Repealer. Amends Laws 2005, ch. 98, art. 3, § 25. Repeals the repealer of Minnesota Statutes 2004, section 245.713, subdivision 2.

21 Revisor's instruction. Instructs the revisor to change references to sections "245.487 to 245.4887" to "245.487 to "245.4889." These sections comprise the Children's

Comprehensive Mental Health Act. Instructs the revisor to correct internal references in section 8.

22 Repealer. Repeals Minnesota Rules, part 9585.0030, regarding reimbursement for compulsive gambling assessors.

Article 9: Department of Health

Overview

This article establishes the Minnesota health insurance exchange, requires employers with more than 10 employees to offer a section 125 plan through the exchange, establishes the MinnesotaCare II option, and makes other related changes.

1 General. Amends section 13.46, subd. 2. Allows data on individuals to be shared between the welfare system and the Minnesota health insurance exchange, in order to enroll and collect premiums from MinnesotaCare enrollees and to administer the MinnesotaCare program.

2 Minnesota health insurance exchange. Adds § 62A.67.

Subd. 1. Title; citation. States that this section may be cited as the "Minnesota Health Insurance Exchange."

Subd. 2. Creation; tax exemption. States that the exchange is created to provide individuals with greater access, choice, portability, and affordability of health insurance products. Provides that the exchange is a not-for-profit corporation under chapter 317A and section 501(c) of the Internal Revenue Code.

Subd. 3. Definitions. Defines terms. "Commissioner" is defined as the commissioner of commerce for health insurers subject to the jurisdiction of that commissioner, and the commissioner of health for health insurers subject to the jurisdiction of that commissioner.

Subd. 4. Insurer and health plan participation. Requires all plans issued or renewed in the individual market to participate in the exchange, and prohibits these plans from being issued or renewed outside of the exchange. Prohibits group health plans from being offered through the exchange. Provides that health plans offered through MCHA are offered through the exchange as determined by MCHA, and that health plans offered through MinnesotaCare and MinnesotaCare II are offered through the exchange as determined by the commissioner of human services.

Subd. 5. Approval of health plans. Prohibits a health plan from being offered through the exchange unless the commissioner has certified that the insurer is licensed to issue health insurance in the state, the health plan meets the requirements of this section, and the health plan and insurer are in compliance with all other applicable laws.

Subd. 6. Individual market health plans. Provides that individual market plans offered through the exchange continue to be regulated by the commissioner as provided in other law and must include the following provisions: (1) premiums for children under age 19 shall not vary by age; and (2) premiums for children under age 19 must excluded from the individual market rating factor requirements related to age in

section 62A.65, subdivision 3, paragraph (b).

Subd. 7. MinnesotaCare II health plans. Requires health plans approved for MinnesotaCare II to be offered by participating insurers to persons not enrolled in MinnesotaCare II.

Subd. 8. Individual participation and eligibility. Allows individuals to purchase health plans directly through the exchange or an employer section 125 plan. States that this section does not require guaranteed issue of individual market health plans offered through the exchange. Provides that individuals are eligible to purchase individual market plans through the exchange by meeting one or more of the following qualifications: (1) the individual is a Minnesota resident; (2) the individual is a student attending an institution outside of Minnesota and maintains Minnesota residency; (3) the individual is not a Minnesota resident but is employed by an employer located in the state, and the employer does not offer a group plan but does offer a section 125 plan through the exchange; (4) the individual is not a Minnesota resident but is self-employed and the principal place of business is in the state; or (5) the individual is a dependent of an eligible individual.

Subd. 9. Continuation of coverage. Allows enrollment in a health plan to be cancelled for nonpayment of premiums, fraud, or changes in MinnesotaCare eligibility. Prohibits enrollment in an individual plan from being cancelled or not renewed due to a change in employer or employment status, marital status, health status, age, residence, or any other change that does not affect eligibility.

Subd. 10. Responsibilities of the exchange. Requires the exchange to serve as the sole entity for enrollment and collection and transfer of premium payments for health plans offered through the exchange. Requires the exchange to: (1) publicize the exchange; (2) provide assistance to employers in setting up a section 125 plan; (3) create a system to allow individuals to compare and enroll in health plans; (4) create a system to collect and transmit premium payments and other contributions to applicable plans; (5) refer individuals interested in MinnesotaCare or MinnesotaCare II to DHS to determine eligibility; (6) establish a mechanism with DHS to transfer MinnesotaCare and MinnesotaCare II premiums and subsidies to qualify for federal matching payments; (7) administer bonus accounts to reimburse MinnesotaCare II enrollees for qualified medical expenses; (8) collect and assess information for eligibility for bonus accounts and premium incentives under chapter 256L; (9) upon request, issue certificates of previous coverage; (10) establish procedures to account for all funds received and disbursed; and (11) make available to the public, at the end of each calendar year, an independent audit.

Subd. 11. Powers of the exchange. Grants the exchange the power to: (1) contract with insurance vendors to perform functions assigned to the exchange; (2) contract with employers to act as the plan administrator for section 125 plans; (3) establish and assess fees on premiums to fund the cost of administration; (4) seek and receive grants; (5) establish and administer rules and procedures to govern operations; (6) establish one or more service centers within the state; (7) sue or be sued and take legal action; (8) establish bank accounts and borrow money; and (9) enter into any necessary agreements with state agencies.

Subd. 12. Dispute resolution. Requires the exchange to establish procedures to

resolve disputes concerning individual eligibility to participate in the exchange. Provides that the exchange does not have the authority or responsibility to intervene in disputes between an individual and a health plan or insurer. Requires the exchange to refer complaints from participants to the commissioner of human services to be resolved according to the complaint resolution procedures that apply to health plan companies.

Subd. 13. Governance. Provides that the exchange is governed by an 11-member board of directors. Requires the board to convene on or before July 1, 2007. Specifies initial board membership.

Subd. 14. Subsequent board membership. Specifies ongoing membership of the board, effective July 1, 2010.

Subd. 15. Operations of the board. Specifies procedures for board operation.

Subd. 16. Operations of the exchange. Requires the board to appoint an exchange director, and specifies duties of the director.

Subd. 17. Insurance producers. Allows health plans to pay producer commissions.

Subd. 18. Implementation. Specifies that health plan coverage through the exchange begins January 1, 2009. Requires the exchange to be operational to provide assistance to individuals and employers by September 1, 2008, and prepared for enrollment by December 1, 2008. Provides that enrollees of individual market plans, MinnesotaCare, and MHCA as of December 2, 2008, are automatically enrolled in the exchange on January 1, 2009, in the same health plan and at the same premium, subject to this section. Requires enrollees to make premium payments to the exchange as of January 1, 2009.

Subd. 19. Study of insurer issue requirements. Requires the exchange, in consultation with the commissioners of commerce and health, to study and present recommendations on rating requirements and risk adjustment mechanisms that would increase enrollment through section 125 plans. Requires findings and recommendations to be reported to the chairs of the legislative committees with jurisdiction over commerce and health, by January 15, 2011.

3 Section 125 plans. Adds § 62A.68.

Subd. 1. Definitions. Defines terms.

Subd. 2. Section 125 plan requirement. Effective January 1, 2009, requires all employers with 11 or more employees to offer a section 125 plan through the exchange, to allow their employees to pay for health insurance premiums with pretax dollars. Exempts from the requirement employers that offer a group insurance plan, offer group health insurance through a self-insured plan, and those with fewer than 11 employees (but allows these employers to voluntarily offer a section 125 plan).

Subd. 3. Tracking compliance. Requires the exchange, in consultation with specified agency commissioners, to establish a method to track employer compliance with the section 125 plan requirement.

Subd. 4. Employer requirements. Requires employers offering a section 125 plan to enter into a binding agreement with the exchange, that includes the following terms:

(a) The employer shall designate the exchange director as the plan's administrator, who shall then agree to undertake these obligations;

(b) The coverage and benefits offered by exchange insurers constitute the coverage and benefits of the employer plan.

(c) Any eligible individual may elect coverage, and neither the employer nor the exchange shall limit choice of coverage from among participating plans.

(d) The employer shall deduct premium amounts on a pretax basis.

(e) The employer shall not offer individuals eligible to participate in the exchange any separate or competing group health plan.

(f) The employer reserves the right to determine the terms and amounts of the employer's contribution to the plan, if any.

(g) The employer shall make available to the exchange records and information necessary to verify employer compliance and individual eligibility.

(h) The exchange shall not provide the employer plan with any services or benefits not otherwise provided or offered to all other employer plans.

Subd. 5. Section 125 eligible health plans. Allows individuals eligible for the exchange through a section 125 plan to enroll in any health plan offered through the exchange for which the individual is eligible.

4 Inclusion in employer-sponsored plan. Amends § 6E.141. Limits the prohibition on employees eligible for employer coverage enrolling in or continuing enrollment in an MCHA plan to enrollees eligible for a group plan.

5 Definitions. Amends § 62J.692, subd. 1. Adds to the definition of "eligible trainee FTEs" to include the number of trainees at training sites located in Minnesota with currently active medical assistance enrollment status and a National Provider Identification number, rather than a medical assistance provider number, as under current statute.

6 Distribution of funds. Amends § 62J.692, subd. 4. Makes changes to the medical education and research grant distribution provision. Sets out the formulas by which the commissioner must distribute money from medical education and research special revenue funds.

7 Clinical medical education innovations grants. Amends § 62J.692, subd. 7a. Adds grants to teaching institutions and clinical training sites for projects that increase access to mental health services to underserved populations and to promote patient safety principles into clinical medical education programs. Adds the potential of a project to impact the number and distribution of the health care workforce to the list of grant considerations.

8 Federal financial participation. Amends § 62J.692, subd. 8. Removes the provision that required the commissioner of health to transfer state funds to the commissioner of human services to maximize federal funds available, if the commissioner of human services determines that federal participation is available for medical education and research.

9 Transfers from University of Minnesota. Amends § 62J.692, subd. 10. Updates a statutory reference.

10 Exceptions. Amends § 62L.12, subd. 2. States that nothing in chapter 62L restricts the offer, sale, issuance or renewal of an individual health plan through the Minnesota Health Insurance Exchange.

11 Fees for variances. Amends 103I.101, subd. 6. Changes the variance fee from $175 to $215. Becomes effective July 1, 2008.

12 Well notification fee. Amends § 103L.208, subd. 1. Increases the well notification fees to be paid by property owners. Provides July 1, 2008 as the effective date.

(1) From $175 to $215 for a new water supply well

(2) From $35 to $50 for well sealing for each well

(3) From $175 to $215 for construction of a dewatering well for each well, and from $875 to $1075 for projects comprising five or more dewatering wells

13 Permit fee. Amends § 103I.208, subd. 2. Increases permit fees paid by property owners. Provides July 1, 2008, as the effective date.

(1) From $150 to $175 for a water supply well that is not in use under a maintenance permit

(2) From $175 to $215 for construction of a monitoring well

(3) From $150 to $175 for a monitoring well that is unsealed under a maintenance permit

(4) From $175 to $215 for the construction fee for monitoring wells used as a leak detection device and from $150 to $175 for an annual fee for a maintenance permit for unsealed monitoring wells

(5) From $175 to $215 for groundwater thermal exchange devices

(6) From $175 to $ 215 for vertical heat exchangers

(7) From $150 to $175 for dewatering well and from $750 to $875 for projects involving five or more wells

(8) From $175 to $215 for an elevator boring

14 Disclosure of wells to buyer. Amends § 103I.235, subd. 1. Increases the fee for a completed well disclosure certificate by $5 and the amount the county recorder or registrar of titles must transfer to the commissioner of health for each well disclosure certificate.

15 Fees for diagnostic laboratory services; exceptions. Amends § 144.123.

Subd. 1. Who must pay. Prohibits a fee for any biological material submitted to or requested by the Department of Health to gather information for disease prevention or control.

Subd. 2. Fee amounts. Requires the commissioner of health to charge handling fees for certain specimens for diagnostic purposes and provides for an increase in these fees.

16 Tests of infants for heritable and congenital disorders. Amends § 144.125.

Subd. 1. Duty to perform testing. Increases the fee the commissioner must charge for the costs of conducting testing for congenital disorders in infants from $61 to $81.

Subd. 2. Determination of tests to be administered. Requires the commissioner to consider the adequacy of analytical methods, rather than laboratory methods, as is currently in statute, when determining whether a certain test must be administered.

Subd. 3. Objection of parents to test. (No change to current statute.)

17 Interconnected electronic health record grants. Amends § 144.3345.

Subd. 1. Definitions. Allows an "eligible community e-health collaborative" to consist of two (rather than three, as in current statute) or more eligible health care entities.

Subd. 2. Grants authorized. Adds to the list of eligible grantee for the interconnected electronic health record grants. Allows for community clinics, regional or community-based health information exchange organizations, community health boards, and boards of health to receive grants. (Currently, only eligible community e-health collaboratives may receive these grants.)

Subd. 3. Allocation of grants. Requires grant applications to include a plan for the used of data exchange standards, in addition to requirements already in statute.

Subd. 4. Evaluation and report. (No change to current statute.)

18 Registration procedures. Amends § 144D.03. Increases the annual fee for annual registration of housing with services establishments from $35 to $155.

19 Audiologist hearing instrument dispensing examination fee. Amends § 148.5194. Requires a fee of $250 for the practical portion of the hearing instrument dispensing exam each time the exam is taken.

20 Initial licensure fee. Amend § 148.6445, subd. 1. Decreases initial licensure fees for occupational therapists from $180 to $145 and for occupational therapy assistants from $100 to $80.

21 Licensure renewal fee. Amends § 148.6445, subd. 2. Decreases biennial licensure renewal fee for occupational therapists from $180 to $145 and for occupational therapy assistants from $100 to $80.

22 Application procedure; documentation; initial inspection. Amends 149A.52, subd. 3. Allows for an appropriate fee to accompany the application for license to operate a crematory.

23 Fees. Adds § 149.65. Sets out the fee requirements for mortuary science.

Subd. 1. Generally. States that this section establishes fees for registrations, examinations, licenses and late fees.

Subd. 2. Mortuary science fees. Sets out the fee schedule for mortuary science

- $50 for the initial and renew registration for interns
- $100 for the mortuary science examination
- $125 for initial and renewal licenses
- $25 late fee for past due license renewals
- $200 for licenses by endorsement

Subd. 3. Funeral directors. Requires a $125 license renewal fee for funeral directors and a $25 late fee.

Subd. 4. Funeral establishments. Requires a $300 initial and renewal fee for funeral

establishments and a $25 late fee.

Subd. 5. Crematories. Requires a $300 initial and renewal fee for crematories and a $25 late fee.

24 Reports to commissioner. Amends § 149A.97, subd. 7. Increases the annual report filing fee for funeral providers from $15 to $25.

25 Trainees. Amends § 153A.14, subd. 4a. Allows a licensed audiologist who meets the requirements of sections 148.511 to 148.5198, but is not certified under this section, to dispense hearing instruments as trainees for a period not longer than 12 months.

26 Expenses; fees. Amends 153A.17. Increases the initial and annual renewal fees for hearing aid dispensers from $350 to $1,000 and the exam fees from $250 to $700. Adds a surcharge of $200 that must be paid at the time of certification application or renewal from July 1, 2007, to June 30, 2011.

27 Financial management. Amends § 256L.02, subd. 3. Requires the commissioner of human services to work with the Minnesota Health Insurance Exchange, when making any program adjustments necessary to ensure that MinnesotaCare expenditures remain within the limits of available revenues. Provides an effective date of January 1, 2009.

28 Enrollment responsibilities. Amends § 256L.02, by adding subd. 5. Effective January 1, 2009, gives the exchange the responsibility for enrolling eligible applicants and enrollees in a health plan for MinnesotaCare coverage. Specifies that the commissioner retains responsibility for determining eligibility. Provides a January 1, 2009, effective date.

29 Exchange of data. Amends § 256L.02, by adding subd. 6. Allows the exchange and an entity that is part of the welfare system to exchange private data about individuals without consent, in order to enroll and collect premiums for MinnesotaCare, and administer participation in the program.

30 Availability of private insurance. Amends § 256L.05, subd. 5. Requires the commissioner to provide information about the exchange upon initial enrollment and annually thereafter. Also requires the notice of ineligibility to provide information about coverage through the exchange. Strikes language requiring information about private sector coverage to be provided to enrollees with certain income levels. Provides a January 1, 2009, effective date.

31 Minnesota health insurance exchange. Amends § 256L.05, by adding subd 6. Requires the commissioner to refer all MinnesotaCare applicants and enrollees to the exchange for enrollment in a managed care plan or private market health plan. Requires the exchange to provide these individuals with assistance in selecting a managed care plan and in analyzing health plans. Provides a January 1, 2009, effective date.

32 MinnesotaCare II option established. Adds § 256L.075.

Subd. 1. Program established; enrollment. Requires the Minnesota Health Insurance Exchange, in consultation with the commissioner, to establish and administer the MinnesotaCare II program that subsidizes the purchase of private market health insurance plans for children in MinnesotaCare families with incomes above 200 percent but not exceeding 300 percent of FPG. Specifies that the coverage is an alternative to standard MinnesotaCare coverage and requires at a minimum, coverage of the standard benefit set established in subdivision 2. Requires enrollment to be administered by the exchange and eligibility to be determined by the commissioner. States that all other provisions of chapter 256L, including the insurance barriers, apply unless otherwise specified.

Subd. 2. Benefit set. Requires the exchange, in consultation with the commissioner, to establish a standard benefit set. Requires review and if necessary, modification, of the benefit set on an annual basis. Allows the benefit to require co-payments, deductibles, and maximum out-of-pocket enrollee cost-sharing limits.

Subd. 3. Health carrier participation. (a) Requires health insurers with at least 3 percent of the market share of premium volume from individual market plans to offer at least one health plan that covers the standard benefit set, or its actuarial equivalent. Requires insurers to offer the standard benefit set, without a subsidy, to adults so families can enroll. Allows insurers not required to participate to do so voluntarily. Requires the exchange to certify plans.

(b) Allows insurers to offer up to three additional health plan products approved by the commissioner of commerce as actuarially equivalent or better than the standard plan. States that these products may also qualify for a subsidy if purchased to cover children.

(c) Provides that this subdivision does not require guaranteed issue of MinnesotaCare II plans.

Subd. 4. State subsidy; premium. States that coverage for children is subsidized based on a sliding scale. Requires the commissioner to pay to the exchange a subsidy for each child equal to the cost of the least expensive health plan, less one-half of the premium that would be paid for the child under section 256L.15, subdivision 2. Provides that the premium for a child is the difference between the cost of the health plan and the subsidy. Requires premiums to be paid to the exchange.

Subd. 5. Enrollment; limitation on changing plans. Allows children to enroll under this section or under section 256L.03 (regular program enrollment). Allows children enrolled under this section to change health plans or switch to the regular MinnesotaCare program at the time of annual renewal, or at other times during the year if the family experiences a qualifying life event or a change in eligibility for state health care programs.

Subd. 6. Bonus accounts incentive. Requires the exchange to administer bonus accounts for families with children enrolled under this section. Requires funds to be credited to a bonus account when goals for preventive services or healthy behaviors are achieved. Allows families to use funds credited to an account to reimburse qualified medical expenses, as defined by the Internal Revenue Code. Requires the commissioner, in consultation with the exchange, to establish a schedule of preventive service and healthy behavior goals and corresponding credit amounts. Allows families to qualify for credits of up to $50 per child, up to a maximum of $150 per year per family. Specifies that these funds are available to a family unit until: (1) there is no longer a child under age 21 in the family; or (2) no child in the family has been enrolled in MA, MinnesotaCare, or an exchange plan for the past six months.

Subd. 7. Federal approval. Requires the commissioner to seek all federal waivers and approvals necessary to implement and receive federal financial participation for expenditures under this section.

Provides a January 1, 2009 effective date.

33 Managed care vendor requirements. Amends § 256L.12, subd. 7. Requires managed care vendors under MinnesotaCare to participate in the exchange for purposes of enrolling individuals. Provides a January 1, 2009, effective date.

34 Payment options. Amends § 256L.15, subd. 1a. States that the exchange is responsible for collecting MinnesotaCare premiums. Provides a January 1, 2009, effective date.

35 Premium discount incentive. Amends § 256L.15, by adding subd. 5. States the adults and families with children are eligible for a premium reduction of $3 per month for each child who meets goals for preventive care or an adult who meets goals for cardiac or diabetes care in the previous calendar year. Sets the maximum premium reduction at $15 per month per family. Requires the commissioner, in consultation with the exchange, to establish goals for preventive care, including cardiac and diabetes care. Requires the premium discount to be administered by the exchange. Specifies that children enrolled in MinnesotaCare II are not eligible for the premium discount incentive. Provides a January 1, 2009, effective date.

36 Repealer. (a) Repeals Minnesota Rules, part 4610.2800, which is the current fee schedule for mortuary science licensure.

(b) Repeals Laws 2004, chapter 288, article 6, section 27, which requires the commissioner to transfer $1,190,000 annually from its general fund appropriation to a statewide organization that is focuses on prevention of fetal alcohol spectrum disorder.