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520.27 **ARTICLE 26**
520.28 **HEALTH DEPARTMENT**

44.10 **ARTICLE 4**
44.11 **HEALTH DEPARTMENT**

H3944-1

520.29 Section 1. Minnesota Statutes 2014, section 13.3805, is amended by adding a
520.30 subdivision to read:

520.31 Subd. 5. **Radon testing and mitigation data.** Data maintained by the Department
520.32 of Health that identify the address of a radon testing or mitigation site, and the name,
521.1 address, e-mail address, and telephone number of residents and residential property owners
521.2 of a radon testing or mitigation site, are private data on individuals or nonpublic data.

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

521.4 Sec. 2. Minnesota Statutes 2014, section 13.3806, subdivision 22, is amended to read:

521.5 Subd. 22. **Medical use of cannabis data.** Data collected under the registry program
521.6 authorized under sections 152.22 to 152.37 are governed by sections 152.25, subdivision
521.7 1; 152.27, subdivision 8; 152.28, subdivision 2; and 152.37, subdivision 3.

521.8 Sec. 3. Minnesota Statutes 2014, section 62D.04, subdivision 1, is amended to read:

521.9 Subdivision 1. **Application review.** Upon receipt of an application for a certificate
521.10 of authority, the commissioner of health shall determine whether the applicant for a
521.11 certificate of authority has:

521.12 (a) demonstrated the willingness and potential ability to assure that health care
521.13 services will be provided in such a manner as to enhance and assure both the availability
521.14 and accessibility of adequate personnel and facilities;

521.15 (b) arrangements for an ongoing evaluation of the quality of health care, including a
521.16 peer review process;

521.17 (c) a procedure to develop, compile, evaluate, and report statistics relating to the
521.18 cost of its operations, the pattern of utilization of its services, the quality, availability and
521.19 accessibility of its services, and such other matters as may be reasonably required by
521.20 regulation of the commissioner of health;

521.21 (d) reasonable provisions for emergency and out of area health care services;

1.10 Section 1. Minnesota Statutes 2014, section 13.3805, is amended by adding a
1.11 subdivision to read:

1.12 Subd. 5. **Radon testing and mitigation data.** Data maintained by the Department
1.13 of Health that identify the address of a radon testing or mitigation site, and the name,
1.14 address, e-mail address, and telephone number of residents and residential property owners
1.15 of a radon testing or mitigation site, are private data on individuals or nonpublic data.

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

(e) demonstrated that it is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner of health shall require the amount of initial net worth required in section 62D.042, compliance with the risk-based capital standards under sections 60A.50 to 60A.592, the deposit required in section 62D.041, and in addition shall consider:

(1) the financial soundness of its arrangements for health care services and the proposed schedule of charges used in connection therewith;

(2) arrangements which will guarantee for a reasonable period of time the continued availability or payment of the cost of health care services in the event of discontinuance of the health maintenance organization; and

(3) agreements with providers for the provision of health care services;

(f) demonstrated that it will assume full financial risk on a prospective basis for the provision of comprehensive health maintenance services, including hospital care; provided, however, that the requirement in this paragraph shall not prohibit the following:

(1) a health maintenance organization from obtaining insurance or making other arrangements (i) for the cost of providing to any enrollee comprehensive health maintenance services, the aggregate value of which exceeds $5,000 in any year, (ii) for the cost of providing comprehensive health care services to its members on a nonelective emergency basis, or while they are outside the area served by the organization, or (iii) for not more than 95 percent of the amount by which the health maintenance organization's costs for any of its fiscal years exceed 105 percent of its income for such fiscal years; and

(2) a health maintenance organization from having a provision in a group health maintenance contract allowing an adjustment of premiums paid based upon the actual health services utilization of the enrollees covered under the contract, except that at no time during the life of the contract shall the contract holder fully self-insure the financial risk of health care services delivered under the contract. Risk sharing arrangements shall be subject to the requirements of sections 62D.01 to 62D.30;

(g) demonstrated that it has made provisions for and adopted a conflict of interest policy applicable to all members of the board of directors and the principal officers of the health maintenance organization. The conflict of interest policy shall include the procedures described in section 317A.255, subdivisions 1 and 2. However, the commissioner is not precluded from finding that a particular transaction is an unreasonable expense as described in section 62D.19 even if the directors follow the required procedures; and

(h) otherwise met the requirements of sections 62D.01 to 62D.30.

Sec. 4. Minnesota Statutes 2014, section 62D.08, subdivision 3, is amended to read:

Subd. 3. **Report requirements.** Such report shall be on forms prescribed by the commissioner of health, and shall include:

(a) a financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent certified public accountant, reflecting at least (1) all prepayment and other payments received for health care services rendered, (2) expenditures to all providers, by classes or groups of providers, and insurance companies or nonprofit health service plan corporations engaged to fulfill obligations arising out of the health maintenance contract, (3) expenditures for capital improvements, or additions thereto, including but not limited to construction, renovation or purchase of facilities and capital equipment, and (4) a supplementary statement of assets, liabilities, premium revenue, and expenditures for risk sharing business under section 62D.04, subdivision 1, on forms prescribed by the commissioner;

(b) the number of new enrollees enrolled during the year, the number of group enrollees and the number of individual enrollees as of the end of the year and the number of enrollees terminated during the year;

(c) a summary of information compiled pursuant to section 62D.04, subdivision 1, clause (c), in such form as may be required by the commissioner of health;

(d) a report of the names and addresses of all persons set forth in section 62D.03, subdivision 4, clause (c), who were associated with the health maintenance organization or the major participating entity during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals for services to the health maintenance organization or the major participating entity, as those services relate to the health maintenance organization, including a full disclosure of all financial arrangements during the preceding year required to be disclosed pursuant to section 62D.03, subdivision 4, clause (d);

(e) a separate report addressing health maintenance contracts sold to individuals covered by Medicare, title XVIII of the Social Security Act, as amended, including the information required under section 62D.30, subdivision 6; ~~and~~

(f) data on the number of complaints received and the category of each complaint as defined by the commissioner. The categories must include but are not limited to access, communication and behavior, health plan administration, facilities and environment, coordination of care, and technical competence and appropriateness. The commissioner must define complaint categories to be used by each health maintenance organization by July 1, 2017, and the categories must be used by each health maintenance organization beginning calendar year 2018; and

~~(f)~~ (g) such other information relating to the performance of the health maintenance organization as is reasonably necessary to enable the commissioner of health to carry out the duties under sections 62D.01 to 62D.30.

Sec. 5. **[62D.115] QUALITY OF CARE COMPLAINTS.**

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Subdivision 1. **Quality of care complaint.** For purposes of this section, "quality of care complaint" means an expressed dissatisfaction regarding health care services resulting in potential or actual harm to an enrollee. Quality of care complaints may include but are not limited to concerns related to provider and staff competence, clinical appropriateness of services, communications, behavior, facility and environmental considerations, or other factors that could impact the quality of health care services.

Subd. 2. **Quality of care complaint investigation.** Each health maintenance organization shall develop and implement policies and procedures for the receipt, investigation, and resolution of quality of care complaints. The policy and procedures must be in writing and must meet the requirements in paragraphs (a) to (g).

(a) A health maintenance organization's definition for quality of care complaints must include the concerns identified in subdivision 1.

(b) A health maintenance organization must classify each quality of care complaint received by severity level as defined by the commissioner and must have investigation procedures for each level of severity.

(c) Any complaint with an allegation regarding quality of care or service must be investigated by the health maintenance organization and the health maintenance organization must document the investigation process, including documentation that the complaint was received and investigated, and that each allegation was addressed. The investigation record must include all related documents, correspondence, summaries, discussions, consultations, and conferences held in relation to the investigation of the quality of care complaint in accordance with subdivision 4.

(d) The resolution of a complaint must be supported by evidence and may include a corrective action plan or a formal response from a provider to the health maintenance organization if a formal response was submitted to the health maintenance organization.

(e) A medical director review shall be conducted as part of the investigation process when there is potential for patient harm.

(f) Each quality of care complaint received by a health maintenance organization must be tracked and trended by the health maintenance organization according to provider type and the following type of quality of care issue: behavior, facility, environmental, or technical competence.

(g) The commissioner shall define the quality of care complaints severity levels by July 1, 2017.

Subd. 3. **Reporting.** (a) Quality of care complaints must be reported as part of the requirements under section 62D.08, subdivision 3.

(b) All quality of care complaints received by a health maintenance organization that meet the highest level of severity as defined by the commissioner under subdivision 2 must be reported to the commissioner within ten calendar days of receipt of the complaint. The commissioner shall investigate each quality of care complaint received under this paragraph and may contract with experts in health care or medical practice to assist with the investigation. The commissioner's investigative process shall include the notification and investigation requirements described in section 214.103 to the extent applicable. The commissioner shall furnish to the person who made the complaint a written description of the commissioner's investigative process and any action taken by the commissioner relating to the complaint, including whether the complaint was referred to the Office of Health Facility Complaints or a health-related licensing board. If the commissioner takes corrective action or requires the health maintenance organization to make any corrective measures of any kind, the nature of the complaint and the action or measures required to be taken are public data.

(c) The commissioner shall forward any quality of care complaint received by a health maintenance organization under this subdivision or received directly from an enrollee of a health maintenance organization that involves the delivery of health care services by a health care provider or facility to the relevant health-related licensing board or state agency for further investigation. Prior to forwarding a complaint to the appropriate board or agency, the commissioner shall obtain the enrollee's consent.

Subd. 4. **Right to external quality of care review.** (a) An enrollee or an individual acting on behalf of an enrollee who files with the commissioner a quality of care complaint that involves a health maintenance organization may submit a written request to the commissioner for an external quality of care review. The enrollee must request an external review within six months from the date of the adverse event that led to the quality of care complaint.

(b) If the enrollee requests an external quality of care review, the health maintenance organization must participate in the external review. The cost of the external quality of care review shall be borne by the health maintenance organization.

Subd. 5. **Contract.** (a) Pursuant to a request for proposal, the commissioner shall contract with at least three organizations or business entities to provide independent external quality of care reviews submitted for external review.

(b) The request for proposal must require that the entity demonstrate:

(1) no conflicts of interest in that it is not owned by, a subsidiary of, or affiliated with a health maintenance organization, utilization review organization, or a trade organization of health care providers;

(2) an expertise in dispute resolution;

(3) an expertise in health-related law;

(4) an ability to conduct reviews using a variety of alternative dispute resolution procedures depending upon the nature of the dispute;

(5) an ability to maintain written records, for at least three years, regarding reviews conducted and provide data to the commissioners of health and commerce upon request on reviews conducted;

(6) an ability to ensure confidentiality of medical records and other enrollee information;

(7) accreditation by a nationally recognized private accrediting organization;

(8) the ability to provide an expedited external review process; and

(9) expertise in clinical medical care and the provision of clinically appropriate medical care to patients.

(c) The contract shall ensure that the fees for the services rendered by the entity in connection with the review are reasonable.

Subd. 6. **Process.** (a) Upon receiving a request for an external quality of care review, the commissioner shall randomly assign the review to one of the external review entities under contract in accordance with subdivision 5. The assigned external review entity must provide immediate notice of the review to the enrollee and to the health maintenance organization. Within ten business days of receiving notice of the review, the health maintenance organization and the enrollee must provide the assigned external review entity with any information that the enrollee wishes to be considered. Each party shall be provided an opportunity to present its version of the facts and arguments. The assigned external review entity must furnish to the health maintenance organization any additional information submitted by the enrollee within one business day of receipt. An enrollee may be assisted or represented by a person of the enrollee's choice.

(b) As part of the external quality of care review process, any aspect of an external review involving the quality of clinical care must be performed by a health care professional with expertise in the medical issue being reviewed.

(c) An external quality of care review shall be made as soon as practical but in no case later than 45 days after receiving the request for an external quality of care review and must promptly send written notice of the decision and the reasons for it to the enrollee, the health maintenance organization, and the commissioner.

(d) The external review entity and the clinical reviewer assigned must not have a material professional, familial, or financial conflict of interest with:

(1) the health maintenance organization that is the subject of the external quality of care review;

(2) the enrollee, or any parties related to the enrollee, whose treatment is the subject of the external quality of care review;

(3) any officer, director, or management employee of the health maintenance organization;

(4) a plan administrator, plan fiduciaries, or plan employees;

(5) the health care provider, the health care provider's group, or practice association recommending treatment that is the subject of the external quality of care review;

(6) the facility at which the recommended treatment would be provided; or

(7) the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended.

(e) An expedited external review must be provided upon the enrollee's request after receiving:

(1) clinical care that involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the enrollee or would jeopardize the enrollee's ability to regain maximum function and the enrollee has simultaneously requested an expedited internal appeal; or

(2) clinical care that concerns an admission, availability of care, continued stay, or health care service for which the enrollee received emergency services but has not been discharged from a facility.

(f) The external review entity must make its expedited determination and any recommendations for actions to ameliorate the effects of adverse clinical care as expeditiously as possible but within no more than 72 hours after the receipt of the request for expedited review and notify the enrollee, the health maintenance organization, and the commissioner of health of the determination.

(g) If the external review entity's notification is not in writing, the external quality of care review entity must provide written confirmation of the determination within 48 hours of the notification.

Subd. 7. **Records; data practices.** Each health maintenance organization shall maintain records of all quality of care complaints and their resolution and retain those records for five years. Notwithstanding section 145.64, the records must be made available to the commissioner upon request. Records provided to the commissioner under this subdivision are confidential data on individuals or protected nonpublic data as defined in section 13.02, subdivision 3 or 13.

Subd. 8. **Exception.** This section does not apply to quality of care complaints received by a health maintenance organization from an enrollee who is covered under a public health care program administered by the commissioner of human services under chapter 256B or 256L.

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Sec. 6. Minnesota Statutes 2014, section 62J.495, subdivision 4, is amended to read:

Subd. 4. **Coordination with national HIT activities.** (a) The commissioner, in consultation with the e-Health Advisory Committee, shall update the statewide implementation plan required under subdivision 2 and released June 2008, to be consistent with the updated Federal HIT Strategic Plan released by the Office of the National Coordinator in accordance with section 3001 of the HITECH Act. The statewide plan shall meet the requirements for a plan required under section 3013 of the HITECH Act.

(b) The commissioner, in consultation with the e-Health Advisory Committee, shall work to ensure coordination between state, regional, and national efforts to support and accelerate efforts to effectively use health information technology to improve the quality and coordination of health care and the continuity of patient care among health care providers, to reduce medical errors, to improve population health, to reduce health disparities, and to reduce chronic disease. The commissioner's coordination efforts shall include but not be limited to:

(1) assisting in the development and support of health information technology regional extension centers established under section 3012(c) of the HITECH Act to provide technical assistance and disseminate best practices; ~~and~~

(2) providing supplemental information to the best practices gathered by regional centers to ensure that the information is relayed in a meaningful way to the Minnesota health care community~~.~~;

(3) providing financial and technical support to Minnesota health care providers to encourage implementation of admission, discharge and transfer alerts, and care summary document exchange transactions and to evaluate the impact of health information technology on cost and quality of care;

(4) providing educational resources and technical assistance to health care providers and patients related to state and national privacy, security, and consent laws governing clinical health information. In carrying out these activities, the commissioner's technical assistance does not constitute legal advice;

Section 1. Minnesota Statutes 2014, section 62J.495, subdivision 4, is amended to read:

Subd. 4. **Coordination with national HIT activities.** (a) The commissioner, in consultation with the e-Health Advisory Committee, shall update the statewide implementation plan required under subdivision 2 and released June 2008, to be consistent with the updated Federal HIT Strategic Plan released by the Office of the National Coordinator in accordance with section 3001 of the HITECH Act. The statewide plan shall meet the requirements for a plan required under section 3013 of the HITECH Act.

(b) The commissioner, in consultation with the e-Health Advisory Committee, shall work to ensure coordination between state, regional, and national efforts to support and accelerate efforts to effectively use health information technology to improve the quality and coordination of health care and the continuity of patient care among health care providers, to reduce medical errors, to improve population health, to reduce health disparities, and to reduce chronic disease. The commissioner's coordination efforts shall include but not be limited to:

(1) assisting in the development and support of health information technology regional extension centers established under section 3012(c) of the HITECH Act to provide technical assistance and disseminate best practices; ~~and~~

(2) providing supplemental information to the best practices gathered by regional centers to ensure that the information is relayed in a meaningful way to the Minnesota health care community;

(3) providing financial and technical support to Minnesota health care providers to encourage implementation of admission, discharge, and transfer alerts and care summary document exchange transactions, and to evaluate the impact of health information technology on cost and quality of care. Communications about available financial and technical support shall include clear information about the interoperable electronic health record requirements in subdivision 1, including a separate statement in boldface type clarifying the exceptions to those requirements;

(4) providing educational resources and technical assistance to health care providers and patients related to state and national privacy, security, and consent laws governing clinical health information, including the requirements of sections 144.291 to 144.298. In carrying out these activities, the commissioner's technical assistance does not constitute legal advice; and

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(5) assessing Minnesota's legal, financial, and regulatory framework for health information exchange, and making recommendations for modifications that would strengthen the ability of Minnesota health care providers to securely exchange data in compliance with patient preferences and in a way that is efficient and financially sustainable; and

(6) seeking public input on both patient impact and costs associated with requirements related to patient consent for release of health records for the purposes of treatment, payment, and health care operations, as required in section 144.293, subdivision 2. The commissioner shall provide a report to the legislature on the findings of this public input process no later than February 1, 2017.

(c) The commissioner, in consultation with the e-Health Advisory Committee, shall monitor national activity related to health information technology and shall coordinate statewide input on policy development. The commissioner shall coordinate statewide responses to proposed federal health information technology regulations in order to ensure that the needs of the Minnesota health care community are adequately and efficiently addressed in the proposed regulations. The commissioner's responses may include, but are not limited to:

(1) reviewing and evaluating any standard, implementation specification, or certification criteria proposed by the national HIT standards committee;

(2) reviewing and evaluating policy proposed by the national HIT policy committee relating to the implementation of a nationwide health information technology infrastructure;

(3) monitoring and responding to activity related to the development of quality measures and other measures as required by section 4101 of the HITECH Act. Any response related to quality measures shall consider and address the quality efforts required under chapter 62U; and

(4) monitoring and responding to national activity related to privacy, security, and data stewardship of electronic health information and individually identifiable health information.

(d) To the extent that the state is either required or allowed to apply, or designate an entity to apply for or carry out activities and programs under section 3013 of the HITECH Act, the commissioner of health, in consultation with the e-Health Advisory Committee and the commissioner of human services, shall be the lead applicant or sole designating authority. The commissioner shall make such designations consistent with the goals and objectives of sections 62J.495 to 62J.497 and 62J.50 to 62J.61.

(e) The commissioner of human services shall apply for funding necessary to administer the incentive payments to providers authorized under title IV of the American Recovery and Reinvestment Act.

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(5) assessing Minnesota's legal, financial, and regulatory framework for health information exchange, including the requirements of sections 144.291 to 144.298, and making recommendations for modifications that would strengthen the ability of Minnesota health care providers to securely exchange data in compliance with patient preferences and in a way that is efficient and financially sustainable.

(c) The commissioner, in consultation with the e-Health Advisory Committee, shall monitor national activity related to health information technology and shall coordinate statewide input on policy development. The commissioner shall coordinate statewide responses to proposed federal health information technology regulations in order to ensure that the needs of the Minnesota health care community are adequately and efficiently addressed in the proposed regulations. The commissioner's responses may include, but are not limited to:

(1) reviewing and evaluating any standard, implementation specification, or certification criteria proposed by the national HIT standards committee;

(2) reviewing and evaluating policy proposed by the national HIT policy committee relating to the implementation of a nationwide health information technology infrastructure;

(3) monitoring and responding to activity related to the development of quality measures and other measures as required by section 4101 of the HITECH Act. Any response related to quality measures shall consider and address the quality efforts required under chapter 62U; and

(4) monitoring and responding to national activity related to privacy, security, and data stewardship of electronic health information and individually identifiable health information.

(d) To the extent that the state is either required or allowed to apply, or designate an entity to apply for or carry out activities and programs under section 3013 of the HITECH Act, the commissioner of health, in consultation with the e-Health Advisory Committee and the commissioner of human services, shall be the lead applicant or sole designating authority. The commissioner shall make such designations consistent with the goals and objectives of sections 62J.495 to 62J.497 and 62J.50 to 62J.61.

(e) The commissioner of human services shall apply for funding necessary to administer the incentive payments to providers authorized under title IV of the American Recovery and Reinvestment Act.

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(f) The commissioner shall include in the report to the legislature information on the activities of this subdivision and provide recommendations on any relevant policy changes that should be considered in Minnesota.

Sec. 7. Minnesota Statutes 2014, section 62J.496, subdivision 1, is amended to read:

Subdivision 1. **Account establishment.** (a) An account is established to:

(1) finance the purchase of certified electronic health records or qualified electronic health records as defined in section 62J.495, subdivision 1a;

(2) enhance the utilization of electronic health record technology, which may include costs associated with upgrading the technology to meet the criteria necessary to be a certified electronic health record or a qualified electronic health record;

(3) train personnel in the use of electronic health record technology; and

(4) improve the secure electronic exchange of health information.

(b) Amounts deposited in the account, including any grant funds obtained through federal or other sources, loan repayments, and interest earned on the amounts shall be used only for awarding loans or loan guarantees, as a source of reserve and security for leveraged loans, for activities authorized in section 62J.495, subdivision 4, or for the administration of the account.

(c) The commissioner may accept contributions to the account from private sector entities subject to the following provisions:

(1) the contributing entity may not specify the recipient or recipients of any loan issued under this subdivision;

(2) the commissioner shall make public the identity of any private contributor to the loan fund, as well as the amount of the contribution provided;

(3) the commissioner may issue letters of commendation or make other awards that have no financial value to any such entity; and

(4) a contributing entity may not specify that the recipient or recipients of any loan use specific products or services, nor may the contributing entity imply that a contribution is an endorsement of any specific product or service.

(d) The commissioner may use the loan funds to reimburse private sector entities for any contribution made to the loan fund. Reimbursement to private entities may not exceed the principle amount contributed to the loan fund.

(e) The commissioner may use funds deposited in the account to guarantee, or purchase insurance for, a local obligation if the guarantee or purchase would improve credit market access or reduce the interest rate applicable to the obligation involved.

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(f) The commissioner shall include in the report to the legislature information on the activities of this subdivision and provide recommendations on any relevant policy changes that should be considered in Minnesota.

Sec. 2. Minnesota Statutes 2014, section 62J.496, subdivision 1, is amended to read:

Subdivision 1. **Account establishment.** (a) An account is established to:

(1) finance the purchase of certified electronic health records or qualified electronic health records as defined in section 62J.495, subdivision 1a;

(2) enhance the utilization of electronic health record technology, which may include costs associated with upgrading the technology to meet the criteria necessary to be a certified electronic health record or a qualified electronic health record;

(3) train personnel in the use of electronic health record technology; and

(4) improve the secure electronic exchange of health information.

(b) Amounts deposited in the account, including any grant funds obtained through federal or other sources, loan repayments, and interest earned on the amounts shall be used only for awarding loans or loan guarantees, as a source of reserve and security for leveraged loans, for activities authorized in section 62J.495, subdivision 4, or for the administration of the account.

(c) The commissioner may accept contributions to the account from private sector entities subject to the following provisions:

(1) the contributing entity may not specify the recipient or recipients of any loan issued under this subdivision;

(2) the commissioner shall make public the identity of any private contributor to the loan fund, as well as the amount of the contribution provided;

(3) the commissioner may issue letters of commendation or make other awards that have no financial value to any such entity; and

(4) a contributing entity may not specify that the recipient or recipients of any loan use specific products or services, nor may the contributing entity imply that a contribution is an endorsement of any specific product or service.

(d) The commissioner may use the loan funds to reimburse private sector entities for any contribution made to the loan fund. Reimbursement to private entities may not exceed the principle amount contributed to the loan fund.

(e) The commissioner may use funds deposited in the account to guarantee, or purchase insurance for, a local obligation if the guarantee or purchase would improve credit market access or reduce the interest rate applicable to the obligation involved.

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(f) The commissioner may use funds deposited in the account as a source of revenue or security for the payment of principal and interest on revenue or general obligation bonds issued by the state if the proceeds of the sale of the bonds will be deposited into the loan fund.

Sec. 8. Minnesota Statutes 2015 Supplement, section 62U.04, subdivision 11, is amended to read:

Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's designee shall only use the data submitted under subdivisions 4 and 5 for the following purposes:

(1) to evaluate the performance of the health care home program as authorized under sections 256B.0751, subdivision 6, and 256B.0752, subdivision 2;

(2) to study, in collaboration with the reducing avoidable readmissions effectively (RARE) campaign, hospital readmission trends and rates;

(3) to analyze variations in health care costs, quality, utilization, and illness burden based on geographical areas or populations;

(4) to evaluate the state innovation model (SIM) testing grant received by the Departments of Health and Human Services, including the analysis of health care cost, quality, and utilization baseline and trend information for targeted populations and communities; and

(5) to compile one or more public use files of summary data or tables that must:

(i) be available to the public for no or minimal cost by March 1, 2016, and available by Web-based electronic data download by June 30, 2019;

(ii) not identify individual patients, payers, or providers;

(iii) be updated by the commissioner, at least annually, with the most current data available;

(iv) contain clear and conspicuous explanations of the characteristics of the data, such as the dates of the data contained in the files, the absence of costs of care for uninsured patients or nonresidents, and other disclaimers that provide appropriate context; and

(v) not lead to the collection of additional data elements beyond what is authorized under this section as of June 30, 2015.

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(f) The commissioner may use funds deposited in the account as a source of revenue or security for the payment of principal and interest on revenue or general obligation bonds issued by the state if the proceeds of the sale of the bonds will be deposited into the loan fund.

(h) The commissioner shall not award new loans or loan guarantees after July 1, 2016.

(b) The commissioner may publish the results of the authorized uses identified in paragraph (a) so long as the data released publicly do not contain information or descriptions in which the identity of individual hospitals, clinics, or other providers may be discerned.

(c) Nothing in this subdivision shall be construed to prohibit the commissioner from using the data collected under subdivision 4 to complete the state-based risk adjustment system assessment due to the legislature on October 1, 2015.

(d) The commissioner or the commissioner's designee may use the data submitted under subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1, ~~2016~~ 2019.

(e) The commissioner shall consult with the all-payer claims database work group established under subdivision 12 regarding the technical considerations necessary to create the public use files of summary data described in paragraph (a), clause (5).

(f) The commissioner shall develop a community input process to advise the commissioner in the identification of high priority analyses to be conducted pursuant to paragraph (a), clause (3), and in the creation of additional public use files of summary data described in paragraph (a), clause (5).

Sec. 9. Minnesota Statutes 2015 Supplement, section 144.061, is amended to read:

144.061 EARLY DENTAL PREVENTION INITIATIVE.

Subdivision 1. **Prevention initiative.** (a) The commissioner of health, in collaboration with the commissioner of human services, shall implement a statewide initiative to increase awareness among communities of color and recent immigrants on the importance of early preventive dental intervention for infants and toddlers before and after primary teeth appear.

(b) The commissioner shall develop educational materials and information for expectant and new parents within the targeted communities that include the importance of early dental care to prevent early cavities, including proper cleaning techniques and feeding habits, before and after primary teeth appear.

(c) The commissioner shall develop a distribution plan to ensure that the materials are distributed to expectant and new parents within the targeted communities, including, but not limited to, making the materials available to health care providers, community clinics, WIC sites, and other relevant sites within the targeted communities.

(d) In developing these materials and distribution plan, the commissioner shall work collaboratively with members of the targeted communities, dental providers, pediatricians, child care providers, and home visiting nurses.

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(e) The commissioner shall, with input from stakeholders listed in paragraph (d), develop and pilot incentives to encourage early dental care within one year of an infant's teeth erupting. Effective July 1, 2017, for the incentives required under this paragraph for fiscal year 2018, the commissioner shall implement the incentive pilot described in subdivision 2.

Subd. 2. **Incentive pilot.** (a) For the purpose of determining the effectiveness of this initiative, the commissioner shall designate up to three communities of color or of recent immigrants, with at least one of the designated communities located outside the seven-county metropolitan area, and work with each designated community to ensure that the educational materials and information are distributed in accordance with subdivision 1. The commissioner shall assist the designated community with developing strategies to encourage early dental care within one year of an infant's teeth erupting, including outreach through ethnic radio, Web casts, and local cable programs, and incentives that are geared toward the ethnic groups residing in the designated communities.

(b) The commissioner shall develop measurable outcomes, including a baseline measurement in order to evaluate whether the educational materials, information, strategies, and incentives increased the numbers of infants and toddlers receiving early preventive dental intervention and care. The evaluation of this incentive pilot shall assist the commissioner with the continued development of community incentives to encourage early dental care within targeted communities required under subdivision 1, paragraph (e).

Sec. 10. **[144.0615] STATEWIDE SCHOOL-BASED SEALANT GRANT PROGRAM.**

(a) The commissioner of health shall develop a statewide coordinated dental sealant program to improve access to preventive dental services for school-aged children. The program shall focus on developing the data tools necessary to identify the public schools in the state with students ages six to nine who are in the greatest need of preventive dental care based on the percentage of students who are low income and who are either enrolled in a public health care program or uninsured, and have no access to a school-based sealant program. In creating this program, the commissioner shall develop an implementation plan that identifies statewide needs, establishes outcome measures, and provides an evaluation process based on the outcome measures established.

(b) The commissioner shall award grants to nonprofit organizations to provide school-based sealant programs. The grants shall be available to expand existing school-based sealant programs and to create new programs in schools that have been identified as underserved high-risk schools.

Senate Language UEH2749-1

(c) By March 15, 2018, the commissioner shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care, describing the implementation plan, including the data tools developed; the outcome measures; the number of grants awarded; and the location of the schools participating in the grants and the results of the evaluation of the program in terms of improving access to sealants for school-aged children ages six to nine.

Sec. 11. **[144.1912] GREATER MINNESOTA FAMILY MEDICINE RESIDENCY GRANT PROGRAM.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Commissioner" means the commissioner of health.

(c) "Eligible family medicine residency program" means a program that meets the following criteria:

(1) is located in Minnesota outside the seven-county metropolitan area, as defined in section 473.121, subdivision 4;

(2) is accredited as a family medicine residency program or is a candidate for accreditation;

(3) is focused on the education and training of family medicine physicians to serve communities outside the metropolitan area; and

(4) demonstrates that over the most recent three years, at least 25 percent of its graduates practice in Minnesota communities outside the metropolitan area.

Subd. 2. **Program administration.** (a) The commissioner shall award family medicine residency grants to existing, eligible, not-for-profit family medicine residency programs to support current and new residency positions. Funds shall be allocated first to proposed new family medicine residency positions, and remaining funds shall be allocated proportionally based on the number of existing residents in eligible programs. The commissioner may fund a new residency position for up to three years.

(b) Grant funds awarded may only be spent to cover the costs of:

(1) establishing, maintaining, or expanding training for family medicine residents;

(2) recruitment, training, and retention of residents and faculty;

(3) travel and lodging for residents; and

(4) faculty, resident, and preceptor salaries.

(c) Grant funds shall not be used to supplant any other government or private funds available for these purposes.

House Language H3467-3

Sec. 3. **[144.1912] GREATER MINNESOTA FAMILY MEDICINE RESIDENCY GRANT PROGRAM.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Commissioner" means the commissioner of health.

(c) "Eligible family medicine residency program" means a program that meets the following criteria:

(1) is located in Minnesota outside the seven-county metropolitan area as defined in section 473.121, subdivision 4;

(2) is accredited as a family medicine residency program or is a candidate for accreditation;

(3) is focused on the education and training of family medicine physicians to serve communities outside the metropolitan area; and

(4) demonstrates that over the most recent three years, at least 25 percent of its graduates practice in Minnesota communities outside the metropolitan area.

Subd. 2. **Program administration.** (a) The commissioner shall award family medicine residency grants to existing, eligible, not-for-profit family medicine residency programs to support current and new residency positions. Funds shall be allocated first to proposed new family medicine residency positions, and remaining funds shall be allocated proportionally based on the number of existing residents in eligible programs. The commissioner may fund a new residency position for up to three years.

(b) Grant funds awarded may only be spent to cover the costs of:

(1) establishing, maintaining, or expanding training for family medicine residents;

(2) recruitment, training, and retention of residents and faculty;

(3) travel and lodging for residents; and

(4) faculty, resident, and preceptor salaries.

(c) Grant funds shall not be used to supplant any other government or private funds available for these purposes.

Senate Language UEH2749-1

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Subd. 3. **Applications.** Eligible family medicine residency programs seeking a grant must apply to the commissioner. The application must include objectives, a related work plan and budget, a description of the number of new and existing residency positions that will be supported using grant funds, and additional information the commissioner determines to be necessary. The commissioner shall determine whether applications are complete and responsive and may require revisions or additional information before awarding a grant.

Subd. 4. **Program oversight.** The commissioner shall require and collect from family medicine residency programs receiving grants, information necessary to administer and evaluate the program. The evaluation shall include the scope of expansion of new residency positions and information describing specific programs to enhance current residency positions, which may include facility improvements. The commissioner shall continue to collect data on greater Minnesota family residency shortages.

Subd. 3. **Applications.** Eligible family medicine residency programs seeking a grant must apply to the commissioner. The application must include objectives, a related work plan and budget, a description of the number of new and existing residency positions that will be supported using grant funds, and additional information the commissioner determines to be necessary. The commissioner shall determine whether applications are complete and responsive and may require revisions or additional information before awarding a grant.

Subd. 4. **Program oversight.** The commissioner may require and collect from family medicine residency programs receiving grants any information necessary to administer and evaluate the program.

Sec. 4. Minnesota Statutes 2014, section 144.293, subdivision 2, is amended to read:

Subd. 2. **Patient consent to release of records.** (a) A provider, or a person who receives health records from a provider, may not release a patient's health records to a person without:

(1) a signed and dated consent from the patient or the patient's legally authorized representative authorizing the release;

(2) specific authorization in law; or

(3) a representation from a provider that holds a signed and dated consent from the patient authorizing the release.

(b) Any consent form signed by a patient must include an option to indicate "yes" or "no" to individual items for which the provider is requesting consent. The provider may not condition the patient's receipt of treatment on the patient's willingness to release records.

H3944-1

Sec. 12. Minnesota Statutes 2015 Supplement, section 144.4961, subdivision 3, is amended to read:

Subd. 3. **Rulemaking.** The commissioner of health shall adopt rules ~~for~~ establishing licensure requirements and ~~enforcement of applicable laws and rules~~ work standards relating to indoor radon in dwellings and other buildings, with the exception of newly constructed Minnesota homes according to section 326B.106, subdivision 6. The commissioner shall coordinate, oversee, and implement all state functions in matters concerning the presence, effects, measurement, and mitigation of risks of radon in dwellings and other buildings.

Sec. 2. Minnesota Statutes 2015 Supplement, section 144.4961, subdivision 3, is amended to read:

Subd. 3. **Rulemaking.** The commissioner of health shall adopt rules ~~for~~ establishing licensure requirements and ~~enforcement of applicable laws and rules~~ work standards relating to indoor radon in dwellings and other buildings, with the exception of newly constructed Minnesota homes according to section 326B.106, subdivision 6. The commissioner shall coordinate, oversee, and implement all state functions in matters concerning the presence, effects, measurement, and mitigation of risks of radon in dwellings and other buildings.

Senate Language UEH2749-1

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

Sec. 13. Minnesota Statutes 2015 Supplement, section 144.4961, subdivision 4, is amended to read:

Subd. 4. **System tag.** All radon mitigation systems installed in Minnesota on or after ~~October 1, 2017~~ January 1, 2018, must have a radon mitigation system tag provided by the commissioner. A radon mitigation professional must attach the tag to the radon mitigation system in a visible location.

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 14. Minnesota Statutes 2015 Supplement, section 144.4961, subdivision 5, is amended to read:

Subd. 5. **License required annually.** Effective January 1, 2018, a license is required annually for every person, firm, or corporation that ~~sells a device or~~ performs a service for compensation to detect the presence of radon in the indoor atmosphere, performs laboratory analysis, or performs a service to mitigate radon in the indoor atmosphere. ~~This section does not apply to retail stores that only sell or distribute radon sampling but are not engaged in the manufacture of radon sampling devices.~~

EFFECTIVE DATE. This section is effective January 1, 2018.

Sec. 15. Minnesota Statutes 2015 Supplement, section 144.4961, subdivision 6, is amended to read:

Subd. 6. **Exemptions.** This section does not apply to:

(1) radon control systems installed in newly constructed Minnesota homes according to section 326B.106, subdivision 6, prior to the issuance of a certificate of occupancy ~~are not required to follow the requirements of this section.~~;

(2) employees of a firm or corporation that installs radon control systems in newly constructed Minnesota homes specified in clause (1);

(3) a person authorized as a building official under Minnesota Rules, part 1300.0070, or that person's designee; or

(4) any person, firm, corporation, or entity that distributes radon testing devices or information for general educational purposes.

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

Senate Language UEH2749-1

Sec. 16. Minnesota Statutes 2015 Supplement, section 144.4961, subdivision 8, is amended to read:

Subd. 8. **Licensing fees.** (a) All radon license applications submitted to the commissioner of health must be accompanied by the required fees. If the commissioner determines that insufficient fees were paid, the necessary additional fees must be paid before the commissioner approves the application. The commissioner shall charge the following fees for each radon license:

(1) Each measurement professional license, ~~$300~~ $150 per year. "Measurement professional" means any person who performs a test to determine the presence and concentration of radon in a building ~~they do~~ the person does not own or lease~~; provides professional or expert advice on radon testing, radon exposure, or health risks related to radon exposure; or makes representations of doing any of these activities~~.

(2) Each mitigation professional license, ~~$500~~ $250 per year. "Mitigation professional" means an individual who ~~performs~~ installs or designs a radon mitigation system in a building ~~they do~~ the individual does not own or lease; ~~provides professional or expert advice on radon mitigation or radon entry routes;~~ or provides on-site supervision of radon mitigation and mitigation technicians~~; or makes representations of doing any of these activities~~. "On-site supervision" means a review at the property of mitigation work upon completion of the work and attachment of a system tag. Employees or subcontractors who are supervised by a licensed mitigation professional are not required to be licensed under this clause. This license also permits the licensee to perform the activities of a measurement professional described in clause (1).

(3) Each mitigation company license, ~~$500~~ $100 per year. "Mitigation company" means any business or government entity that performs or authorizes employees to perform radon mitigation. This fee is waived if the mitigation company ~~is a sole proprietorship~~ employs only one licensed mitigation professional.

(4) Each radon analysis laboratory license, $500 per year. "Radon analysis laboratory" means a business entity or government entity that analyzes passive radon detection devices to determine the presence and concentration of radon in the devices. This fee is waived if the laboratory is a government entity and is only distributing test kits for the general public to use in Minnesota.

(5) Each Minnesota Department of Health radon mitigation system tag, $75 per tag. "Minnesota Department of Health radon mitigation system tag" or "system tag" means a unique identifiable radon system label provided by the commissioner of health.

(b) Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

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

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Sec. 6. Minnesota Statutes 2015 Supplement, section 144.4961, subdivision 8, is amended to read:

Subd. 8. **Licensing fees.** (a) All radon license applications submitted to the commissioner of health must be accompanied by the required fees. If the commissioner determines that insufficient fees were paid, the necessary additional fees must be paid before the commissioner approves the application. The commissioner shall charge the following fees for each radon license:

(1) Each measurement professional license, ~~$300~~ $150 per year. "Measurement professional" means any person who performs a test to determine the presence and concentration of radon in a building ~~they do~~ the person does not own or lease~~; provides professional or expert advice on radon testing, radon exposure, or health risks related to radon exposure; or makes representations of doing any of these activities~~.

(2) Each mitigation professional license, ~~$500~~ $250 per year. "Mitigation professional" means an individual who ~~performs~~ installs or designs a radon mitigation system in a building ~~they do~~ the individual does not own or lease~~; provides professional or expert advice on radon mitigation or radon entry routes;~~ or provides on-site supervision of radon mitigation and mitigation technicians~~; or makes representations of doing any of these activities~~. "On-site supervision" means a review at the property of mitigation work upon completion of the work and attachment of a system tag. Employees or subcontractors who are supervised by a licensed mitigation professional are not required to be licensed under this clause. This license also permits the licensee to perform the activities of a measurement professional described in clause (1).

(3) Each mitigation company license, ~~$500~~ $100 per year. "Mitigation company" means any business or government entity that performs or authorizes employees to perform radon mitigation. This fee is waived if the mitigation company ~~is a sole proprietorship~~ employs only one licensed mitigation professional.

(4) Each radon analysis laboratory license, $500 per year. "Radon analysis laboratory" means a business entity or government entity that analyzes passive radon detection devices to determine the presence and concentration of radon in the devices. This fee is waived if the laboratory is a government entity and is only distributing test kits for the general public to use in Minnesota.

(5) Each Minnesota Department of Health radon mitigation system tag, $75 per tag. "Minnesota Department of Health radon mitigation system tag" or "system tag" means a unique identifiable radon system label provided by the commissioner of health.

(b) Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

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

Senate Language UEH2749-1

Sec. 17. Minnesota Statutes 2015 Supplement, section 144.4961, is amended by adding a subdivision to read:

Subd. 10. **Local inspections or permits.** This section does not preclude local units of government from requiring additional permits or inspections for radon control systems, and does not supersede any local inspection or permit requirements.

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

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Sec. 7. Minnesota Statutes 2015 Supplement, section 144.4961, is amended by adding a subdivision to read:

Subd. 10. **Local inspections or permits.** This section does not preclude local units of government from requiring additional permits or inspections for radon control systems, and does not supersede any local inspection or permit requirements.

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

Sec. 8. Minnesota Statutes 2015 Supplement, section 144.4961, is amended by adding a subdivision to read:

Subd. 11. **Application; newly constructed homes.** This section does not apply to newly constructed Minnesota homes according to section 326B.106, subdivision 6, prior to the issuance of a certificate of occupancy.

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

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Sec. 5. **[144.7011] PRESCRIPTION DRUG PRICE REPORTING.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Available discount" means any reduction in the usual and customary price offered for a 30-day supply of a prescription drug to individuals in Minnesota regardless of their health insurance coverage.

(c) "Retail pharmacy" means any pharmacy licensed under section 151.19, and in the community/outpatient category under Minnesota Rules, part 6800.0350, that has a physical presence in Minnesota.

(d) "Retail price" means the price maintained by pharmacies as the usual and customary price offered for a 30-day supply to individuals in Minnesota regardless of the individual's health insurance coverage.

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Subd. 2. **Prescription drug price information reporting.** By July 1, 2017, the commissioner of health shall establish an interactive Web site that allows retail pharmacies, on a voluntary basis, to list retail prices and available discounts for one or more of the 150 most commonly dispensed prescription drugs in Minnesota. The Web site must report the retail prices for prescription drugs by participating pharmacy and any time period restriction on an available discount. The Web site must allow consumers to search for prescription drug retail prices by drug name and class, by available discount level, and by city, county, and zip code. The commissioner shall consult annually with the commissioner of human services to determine the list of the 150 most commonly filled prescription drugs, based on prescription drug utilization in the medical assistance and MinnesotaCare programs.

Subd. 3. **Pharmacy duties.** Beginning on June 1, 2017, and on a monthly basis thereafter, all participating retail pharmacies shall submit retail prices and available discounts to the commissioner using a form developed by the commissioner. A retail pharmacy may opt out of the reporting system at any time, but shall notify the commissioner at least 60 days prior to opting out.

Subd. 4. **External vendors.** In carrying out the duties of this section, the commissioner may contract with an outside vendor for collection of data from pharmacies, and may also contract with an outside vendor for development and hosting of the interactive application, if this contract complies with the requirements of section 16E.016, paragraph (c).

Sec. 6. Minnesota Statutes 2014, section 144A.471, subdivision 9, is amended to read:

Subd. 9. **Exclusions from home care licensure.** The following are excluded from home care licensure and are not required to provide the home care bill of rights:

(1) an individual or business entity providing only coordination of home care that includes one or more of the following:

(i) determination of whether a client needs home care services, or assisting a client in determining what services are needed;

(ii) referral of clients to a home care provider;

(iii) administration of payments for home care services; or

(iv) administration of a health care home established under section 256B.0751;

(2) an individual who is not an employee of a licensed home care provider if the individual:

(i) only provides services as an independent contractor to one or more licensed home care providers;

(ii) provides no services under direct agreements or contracts with clients; and

(iii) is contractually bound to perform services in compliance with the contracting home care provider's policies and service plans;

(3) a business that provides staff to home care providers, such as a temporary employment agency, if the business:

(i) only provides staff under contract to licensed or exempt providers;

(ii) provides no services under direct agreements with clients; and

(iii) is contractually bound to perform services under the contracting home care provider's direction and supervision;

(4) any home care services conducted by and for the adherents of any recognized church or religious denomination for its members through spiritual means, or by prayer for healing;

(5) an individual who only provides home care services to a relative;

(6) an individual not connected with a home care provider that provides assistance with basic home care needs if the assistance is provided primarily as a contribution and not as a business;

(7) an individual not connected with a home care provider that shares housing with and provides primarily housekeeping or homemaking services to an elderly or disabled person in return for free or reduced-cost housing;

(8) an individual or provider providing home-delivered meal services;

(9) an individual providing senior companion services and other older American volunteer programs (OAVP) established under the Domestic Volunteer Service Act of 1973, United States Code, title 42, chapter 66;

(10) an employee of a nursing home or home care provider licensed under this chapter or an employee of a boarding care home licensed under sections 144.50 to 144.56 who responds to occasional emergency calls from individuals residing in a residential setting that is attached to or located on property contiguous to the nursing home ~~or~~, boarding care home, or location where home care services are also provided;

(11) an employee of a nursing home or home care provider licensed under this chapter or an employee of a boarding care home licensed under sections 144.50 to 144.56 who provides occasional minor services free of charge to individuals residing in a residential setting that is attached to or located on property contiguous to the nursing home, boarding care home, or location where home care services are also provided, for the occasional minor services provided free of charge;

~~(11)~~ (12) a member of a professional corporation organized under chapter 319B that does not regularly offer or provide home care services as defined in section 144A.43, subdivision 3;

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~~(12)~~ (13) the following organizations established to provide medical or surgical services that do not regularly offer or provide home care services as defined in section 144A.43, subdivision 3: a business trust organized under sections 318.01 to 318.04, a nonprofit corporation organized under chapter 317A, a partnership organized under chapter 323, or any other entity determined by the commissioner;

~~(13)~~ (14) an individual or agency that provides medical supplies or durable medical equipment, except when the provision of supplies or equipment is accompanied by a home care service;

~~(14)~~ (15) a physician licensed under chapter 147;

~~(15)~~ (16) an individual who provides home care services to a person with a developmental disability who lives in a place of residence with a family, foster family, or primary caregiver;

~~(16)~~ (17) a business that only provides services that are primarily instructional and not medical services or health-related support services;

~~(17)~~ (18) an individual who performs basic home care services for no more than 14 hours each calendar week to no more than one client;

~~(18)~~ (19) an individual or business licensed as hospice as defined in sections 144A.75 to 144A.755 who is not providing home care services independent of hospice service;

~~(19)~~ (20) activities conducted by the commissioner of health or a community health board as defined in section 145A.02, subdivision 5, including communicable disease investigations or testing; or

~~(20)~~ (21) administering or monitoring a prescribed therapy necessary to control or prevent a communicable disease, or the monitoring of an individual's compliance with a health directive as defined in section 144.4172, subdivision 6.

Sec. 18. Minnesota Statutes 2014, section 144A.75, subdivision 5, is amended to read:

Subd. 5. **Hospice provider.** "Hospice provider" means an individual, organization, association, corporation, unit of government, or other entity that is regularly engaged in the delivery, directly or by contractual arrangement, of hospice services for a fee to ~~terminally ill~~ hospice patients. A hospice must provide all core services.

Sec. 7. Minnesota Statutes 2014, section 144A.75, subdivision 5, is amended to read:

Subd. 5. **Hospice provider.** "Hospice provider" means an individual, organization, association, corporation, unit of government, or other entity that is regularly engaged in the delivery, directly or by contractual arrangement, of hospice services for a fee to ~~terminally ill~~ hospice patients. A hospice must provide all core services.

Sec. 19. Minnesota Statutes 2014, section 144A.75, subdivision 6, is amended to read:

Subd. 6. **Hospice patient.** "Hospice patient" means an individual ~~who has been diagnosed as terminally ill, with a probable life expectancy of under one year, as~~ whose illness has been documented by the individual's attending physician and hospice medical director, who alone or, when unable, through the individual's family has voluntarily consented to and received admission to a hospice provider, and who:

Sec. 8. Minnesota Statutes 2014, section 144A.75, subdivision 6, is amended to read:

Subd. 6. **Hospice patient.** "Hospice patient" means an individual ~~who has been diagnosed as terminally ill, with a probable life expectancy of under one year, as~~ whose illness has been documented by the individual's attending physician and hospice medical director, who alone or, when unable, through the individual's family has voluntarily consented to and received admission to a hospice provider, and who:

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(1) has been diagnosed as terminally ill, with a probable life expectancy of under one year; or

(2) is 21 years of age or younger and has been diagnosed with a life-threatening illness contributing to a shortened life expectancy.

Sec. 20. Minnesota Statutes 2014, section 144A.75, subdivision 8, is amended to read:

Subd. 8. **Hospice services; hospice care.** "Hospice services" or "hospice care" means palliative and supportive care and other services provided by an interdisciplinary team under the direction of an identifiable hospice administration to ~~terminally ill~~ hospice patients and their families to meet the physical, nutritional, emotional, social, spiritual, and special needs experienced during the final stages of illness, dying, and bereavement, or during a life-threatening illness contributing to a shortened life expectancy. These services are provided through a centrally coordinated program that ensures continuity and consistency of home and inpatient care that is provided directly or through an agreement.

Sec. 21. Minnesota Statutes 2015 Supplement, section 144A.75, subdivision 13, is amended to read:

Subd. 13. **Residential hospice facility.** (a) "Residential hospice facility" means a facility that resembles a single-family home modified to address life safety, accessibility, and care needs, located in a residential area that directly provides 24-hour residential and support services in a home-like setting for hospice patients as an integral part of the continuum of home care provided by a hospice and that houses:

(1) no more than eight hospice patients; or

(2) at least nine and no more than 12 hospice patients with the approval of the local governing authority, notwithstanding section 462.357, subdivision 8.

(b) Residential hospice facility also means a facility that directly provides 24-hour residential and support services for hospice patients and that:

(1) houses no more than 21 hospice patients;

(2) meets hospice certification regulations adopted pursuant to title XVIII of the federal Social Security Act, United States Code, title 42, section 1395, et seq.; and

(3) is located on St. Anthony Avenue in St. Paul, Minnesota, and was licensed as a 40-bed non-Medicare certified nursing home as of January 1, 2015.

Sec. 22. Minnesota Statutes 2014, section 144A.75, is amended by adding a subdivision to read:

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(1) has been diagnosed as terminally ill, with a probable life expectancy of under one year; or

(2) is 21 years of age or younger; has been diagnosed with a chronic, complex, and life-threatening illness contributing to a shortened life expectancy; and is not expected to survive to adulthood.

Sec. 9. Minnesota Statutes 2014, section 144A.75, subdivision 8, is amended to read:

Subd. 8. **Hospice services; hospice care.** "Hospice services" or "hospice care" means palliative and supportive care and other services provided by an interdisciplinary team under the direction of an identifiable hospice administration to terminally ill hospice patients and their families to meet the physical, nutritional, emotional, social, spiritual, and special needs experienced during the final stages of illness, dying, and bereavement, or during a chronic, complex, and life-threatening illness contributing to a shortened life expectancy for hospice patients who meet the criteria in subdivision 6, clause (2). These services are provided through a centrally coordinated program that ensures continuity and consistency of home and inpatient care that is provided directly or through an agreement.

Sec. 10. Minnesota Statutes 2015 Supplement, section 144A.75, subdivision 13, is amended to read:

Subd. 13. **Residential hospice facility.** (a) "Residential hospice facility" means a facility that resembles a single-family home modified to address life safety, accessibility, and care needs, located in a residential area that directly provides 24-hour residential and support services in a home-like setting for hospice patients as an integral part of the continuum of home care provided by a hospice and that houses:

(1) no more than eight hospice patients; or

(2) at least nine and no more than 12 hospice patients with the approval of the local governing authority, notwithstanding section 462.357, subdivision 8.

(b) Residential hospice facility also means a facility that directly provides 24-hour residential and support services for hospice patients and that:

(1) houses no more than 21 hospice patients;

(2) meets hospice certification regulations adopted pursuant to title XVIII of the federal Social Security Act, United States Code, title 42, section 1395, et seq.; and

(3) is located on St. Anthony Avenue in St. Paul, Minnesota, and was licensed as a 40-bed non-Medicare certified nursing home as of January 1, 2015.

Sec. 11. Minnesota Statutes 2014, section 144A.75, is amended by adding a subdivision to read:

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Subd. 13a. **Respite care.** "Respite care" means short-term care in an inpatient facility such as a residential hospice facility, when necessary to relieve the hospice patient's family or other persons caring for the patient. Respite care may be provided on an occasional basis.

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Subd. 13a. **Respite care.** "Respite care" means short-term care in an inpatient facility, such as a residential hospice facility, when necessary to relieve the hospice patient's family or other persons caring for the patient. Respite care may be provided on an occasional basis.

Sec. 12. Minnesota Statutes 2015 Supplement, section 145.4131, subdivision 1, is amended to read:

Subdivision 1. **Forms.** (a) Within 90 days of July 1, 1998, the commissioner shall prepare a reporting form for use by physicians or facilities performing abortions. A copy of this section shall be attached to the form. A physician or facility performing an abortion shall obtain a form from the commissioner.

(b) The form shall require the following information:

(1) the number of abortions performed by the physician in the previous calendar year, reported by month;

(2) the method used for each abortion;

(3) the approximate gestational age expressed in one of the following increments:

(i) less than nine weeks;

(ii) nine to ten weeks;

(iii) 11 to 12 weeks;

(iv) 13 to 15 weeks;

(v) 16 to 20 weeks;

(vi) 21 to 24 weeks;

(vii) 25 to 30 weeks;

(viii) 31 to 36 weeks; or

(ix) 37 weeks to term;

(4) the age of the woman at the time the abortion was performed;

(5) the specific reason for the abortion, including, but not limited to, the following:

(i) the pregnancy was a result of rape;

(ii) the pregnancy was a result of incest;

(iii) economic reasons;

(iv) the woman does not want children at this time;

(v) the woman's emotional health is at stake;

(vi) the woman's physical health is at stake;

(vii) the woman will suffer substantial and irreversible impairment of a major bodily function if the pregnancy continues;

(viii) the pregnancy resulted in fetal anomalies; or

(ix) unknown or the woman refused to answer;

(6) the number of prior induced abortions;

(7) the number of prior spontaneous abortions;

(8) whether the abortion was paid for by:

(i) private coverage;

(ii) public assistance health coverage; or

(iii) self-pay;

(9) whether coverage was under:

(i) a fee-for-service plan;

(ii) a capitated private plan; or

(iii) other;

(10) complications, if any, for each abortion and for the aftermath of each abortion. Space for a description of any complications shall be available on the form;

(11) the medical specialty of the physician performing the abortion; ~~and~~

(12) if the abortion was performed via telemedicine, the facility code for the patient and the facility code for the physician; and

~~(12)~~ (13) whether the abortion resulted in a born alive infant, as defined in section 145.423, subdivision 4, and:

(i) any medical actions taken to preserve the life of the born alive infant;

(ii) whether the born alive infant survived; and

(iii) the status of the born alive infant, should the infant survive, if known.

EFFECTIVE DATE. This section is effective January 1, 2017.

Senate Language UEH2749-1

House Language H3467-3

Sec. 13. **[145.417] LICENSURE OF CERTAIN FACILITIES THAT PERFORM ABORTIONS.**

Subdivision 1. **License required for facilities that perform ten or more abortions per month.** (a) A clinic, health center, or other facility in which the pregnancies of ten or more women known to be pregnant are willfully terminated or aborted each month shall be licensed by the commissioner of health and, notwithstanding Minnesota Rules, part 4675.0100, subparts 8 and 9, subject to the licensure requirements provided in Minnesota Rules, chapter 4675. The commissioner shall not require a facility licensed as a hospital or as an outpatient surgical center, pursuant to sections 144.50 to 144.56, to obtain a separate license under this section, but may subject these facilities to inspections and investigations as permitted under subdivision 2.

(b) The commissioner of health, the attorney general, an appropriate county attorney, or a woman upon whom an abortion has been performed or attempted to be performed at an unlicensed facility may seek an injunction in district court against the continued operation of the facility. Proceedings for securing an injunction may be brought by the attorney general or by the appropriate county attorney.

(c) Sanctions provided in this subdivision do not restrict other available sanctions.

Subd. 2. **Inspections; no notice required.** No more than two times per year, the commissioner of health shall perform routine and comprehensive inspections and investigations of facilities described under subdivision 1. Every clinic, health center, or other facility described under subdivision 1, and any other premises proposed to be conducted as a facility by an applicant for a license, shall be open at all reasonable times to inspection authorized in writing by the commissioner of health. No notice need be given to any person prior to any inspection.

Subd. 3. **Licensure fee.** (a) The annual license fee for facilities required to be licensed under this section is $3,712.

(b) Fees shall be collected and deposited according to section 144.122.

Subd. 4. **Suspension, revocation, and refusal to renew.** The commissioner of health may refuse to grant or renew, or may suspend or revoke a license on any of the following grounds:

(1) violation of any of the provisions of this section or Minnesota Rules, chapter 4675;

(2) permitting, aiding, or abetting the commission of any illegal act in the facility;

(3) conduct or practices detrimental to the welfare of the patient;

(4) obtaining or attempting to obtain a license by fraud or misrepresentation; or

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(5) if there is a pattern of conduct that involves one or more physicians in the facility who have a financial or economic interest in the facility, as defined in section 144.6521, subdivision 3, and who have not provided notice and disclosure of the financial or economic interest as required by section 144.6521.

Subd. 5. **Hearing.** Prior to any suspension, revocation, or refusal to renew a license, the licensee shall be entitled to notice and a hearing as provided by sections 14.57 to 14.69. At each hearing, the commissioner of health shall have the burden of establishing that a violation described in subdivision 4 has occurred. If a license is revoked, suspended, or not renewed, a new application for a license may be considered by the commissioner if the conditions upon which revocation, suspension, or refusal to renew was based have been corrected and evidence of this fact has been satisfactorily furnished. A new license may be granted after proper inspection has been made and all provisions of this section and Minnesota Rules, chapter 4675, have been complied with and a recommendation for licensure has been made by the commissioner or by an inspector as an agent of the commissioner.

Subd. 6. **Severability.** If any one or more provision, section, subdivision, sentence, clause, phrase, or word of this section or the application of it to any person or circumstance is found to be unconstitutional, it is declared to be severable and the balance of this section shall remain effective notwithstanding such unconstitutionality. The legislature intends that it would have passed this section, and each provision, section, subdivision, sentence, clause, phrase, or word, regardless of the fact that any one provision, section, subdivision, sentence, clause, phrase, or word is declared unconstitutional.

Sec. 16. Minnesota Statutes 2014, section 145.882, subdivision 2, is amended to read:

Subd. 2. **Allocation to commissioner of health.** (a) Beginning January 1, 1986, up to one-third of the total maternal and child health block grant money may be retained by the commissioner of health to:

(1) meet federal maternal and child block grant requirements of a statewide needs assessment every five years and prepare the annual federal block grant application and report;

(2) collect and disseminate statewide data on the health status of mothers and children within one year of the end of the year;

(3) provide technical assistance to community health boards in meeting statewide outcomes;

(4) evaluate the impact of maternal and child health activities on the health status of mothers and children;

(5) provide services to children under age 16 receiving benefits under title XVI of the Social Security Act; and

(6) perform other maternal and child health activities listed in section 145.88 and as deemed necessary by the commissioner.

(b) Any money under this subdivision used by the commissioner for grants for the provision of prepregnancy family planning services must be distributed under section 145.925.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 17. Minnesota Statutes 2014, section 145.882, subdivision 3, is amended to read:

Subd. 3. **Allocation to community health boards.** (a) The maternal and child health block grant money remaining after distributions made under subdivision 2 and used for services other than prepregnancy family planning services must be allocated according to the formula in section 145A.131, subdivision 2, for distribution to community health boards. Maternal and child health block grant money used for the provision of prepregnancy family planning services must be distributed under section 145.925.

(b) A community health board that receives funding under this section shall provide at least a 50 percent match for funds received under United States Code, title 42, sections 701 to 709. Eligible funds must be used to meet match requirements. Eligible funds include funds from local property taxes, reimbursements from third parties, fees, other funds, donations, nonfederal grants, or state funds received under the local public health grant defined in section 145A.131, that are used for maternal and child health activities as described in subdivision 7.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 18. Minnesota Statutes 2014, section 145.882, subdivision 7, is amended to read:

Subd. 7. **Use of block grant money.** Maternal and child health block grant money allocated to a community health board under this section must be used for qualified programs for high risk and low-income individuals. Block grant money allocated under this section or for family planning services under section 145.925 must be used for programs that:

(1) specifically address the highest risk populations, particularly low-income and minority groups with a high rate of infant mortality and children with low birth weight, by providing services, including prepregnancy family planning services, calculated to produce measurable decreases in infant mortality rates, instances of children with low birth weight, and medical complications associated with pregnancy and childbirth, including infant mortality, low birth rates, and medical complications arising from chemical abuse by a mother during pregnancy;

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(2) specifically target pregnant women whose age, medical condition, maternal history, or chemical abuse substantially increases the likelihood of complications associated with pregnancy and childbirth or the birth of a child with an illness, disability, or special medical needs;

(3) specifically address the health needs of young children who have or are likely to have a chronic disease or disability or special medical needs, including physical, neurological, emotional, and developmental problems that arise from chemical abuse by a mother during pregnancy;

(4) provide family planning and preventive medical care for specifically identified target populations, such as minority and low-income teenagers, in a manner calculated to decrease the occurrence of inappropriate pregnancy and minimize the risk of complications associated with pregnancy and childbirth;

(5) specifically address the frequency and severity of childhood and adolescent health issues, including injuries in high risk target populations by providing services calculated to produce measurable decreases in mortality and morbidity;

(6) specifically address preventing child abuse and neglect, reducing juvenile delinquency, promoting positive parenting and resiliency in children, and promoting family health and economic sufficiency through public health nurse home visits under section 145A.17; or

(7) specifically address nutritional issues of women, infants, and young children through WIC clinic services.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 19. **[145.908] GRANT PROGRAM; SCREENING AND TREATMENT FOR PRE- AND POSTPARTUM MOOD AND ANXIETY DISORDERS.**

Subdivision 1. **Grant program established.** Within the limits of federal funds available specifically for this purpose, the commissioner of health shall establish a grant program to provide culturally competent programs to screen and treat pregnant women and women who have given birth in the preceding 12 months for pre- and postpartum mood and anxiety disorders. Organizations may use grant funds to establish new screening or treatment programs, or expand or maintain existing screening or treatment programs. In establishing the grant program, the commissioner shall prioritize expanding or enhancing screening for pre- and postpartum mood and anxiety disorders in primary care settings. The commissioner shall determine the types of organizations eligible for grants.

Subd. 2. **Allowable uses of funds.** Grant funds awarded by the commissioner under this section:

(1) must be used to provide health care providers with appropriate training and relevant resources on screening, treatment, follow-up support, and links to community-based resources for pre- and postpartum mood and anxiety disorders; and

(2) may be used to:

(i) enable health care providers to provide or receive psychiatric consultations to treat eligible women for pre- and postpartum mood and anxiety disorders;

(ii) conduct a public awareness campaign;

(iii) fund startup costs for telephone lines, Web sites, and other resources to collect and disseminate information about screening and treatment for pre- and postpartum mood and anxiety disorders; or

(iv) establish connections between community-based resources.

Subd. 3. **Federal funds.** The commissioner shall apply for any available grant funds from the federal Department of Health and Human Services for this program.

Sec. 20. Minnesota Statutes 2014, section 145.925, subdivision 1, is amended to read:

Subdivision 1. ~~**Eligible organizations;**~~ **Purpose.** The commissioner of health ~~may~~ shall make ~~special~~ grants ~~to cities, counties, groups of cities or counties, or nonprofit corporations~~ to provide prepregnancy family planning services.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 21. Minnesota Statutes 2014, section 145.925, subdivision 1a, is amended to read:

Subd. 1a. ~~**Family planning services; defined**~~ **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "Community health board" has the meaning given in section 145A.02, subdivision 5.

(c) "Family planning" means voluntary action by individuals to prevent or aid conception.

(d) "Family planning services" means counseling by trained personnel regarding family planning; distribution of information relating to family planning~~,~~; referral to licensed physicians or local health agencies for consultation, examination, medical treatment, genetic counseling, and prescriptions for the purpose of family planning; and the distribution of family planning products, such as charts, thermometers, drugs, medical preparations, and contraceptive devices. For purposes of sections 145A.01 to 145A.14, family planning shall mean voluntary action by individuals to prevent or aid conception but does not include the performance, or make referrals for encouragement of voluntary termination of pregnancy.

(e) "Federally qualified health center" has the meaning given in section 145.9269, subdivision 1.

(f) "Hospital" means a facility licensed as a hospital under section 144.55.

(g) "Public health clinic" means a health clinic operated by one or more local units of government or community health boards or by the University of Minnesota and that has as a primary focus the provision of primary and preventive health care services and immunizations.

(h) "Rural health clinic" means a rural health clinic as defined in United States Code, title 42, section 1395x(aa)(2) that is certified according to Code of Federal Regulations, title 42, part 491, subpart A.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 22. Minnesota Statutes 2014, section 145.925, is amended by adding a subdivision to read:

Subd. 1b. **Commissioner to apply for federal Title X funds.** For each federal Title X grant fund cycle, the commissioner shall apply to the federal Department of Health and Human Services for grant funds under Title X of the federal Public Health Service Act, United States Code, title 42, sections 300 to 300a-6.

EFFECTIVE DATE. This section is effective beginning with the federal 2018 application deadline for Title X grant funds.

Sec. 23. Minnesota Statutes 2014, section 145.925, is amended by adding a subdivision to read:

Subd. 1c. **State and federal funds distributed according to this section.** The commissioner shall distribute the following funds according to subdivision 1d:

(1) federal Title X funds received by the commissioner according to an application submitted under subdivision 1b;

(2) funds appropriated from the general fund and the federal TANF fund for purposes of grants under this section; and

(3) maternal and child health block grant funds used for prepregnancy family planning services.

EFFECTIVE DATE. This section is effective July 1, 2017.

Senate Language UEH2749-1

House Language H3467-3

Sec. 24. Minnesota Statutes 2014, section 145.925, is amended by adding a subdivision to read:

Subd. 1d. **Distribution; eligible entities.** The commissioner shall distribute the funds specified in subdivision 1c to public entities, including community health boards and public health clinics, that apply to the commissioner for funds to provide family planning services according to procedures established by the commissioner. If any funds remain after the commissioner fulfills all approved grant requests from public entities for the grant period, the commissioner may distribute the remaining funds to nonpublic entities that:

(1) are hospitals, federally qualified health centers, or rural health clinics;

(2) provide comprehensive primary and preventive health care services in addition to family planning services; and

(3) apply to the commissioner for funds to provide family planning services according to procedures established by the commissioner.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 25. Minnesota Statutes 2014, section 145.925, is amended by adding a subdivision to read:

Subd. 1e. **Subgrants from public entities.** (a) A public entity that receives funds from the commissioner under subdivision 1d may distribute some or all of the funds as subgrants to other public or private entities to provide family planning services. Except as provided in paragraph (b), an entity is not eligible for a subgrant under this subdivision if the entity provides abortion services or has an affiliate that provides abortion services.

(b) An entity that provides abortion services or has an affiliate that provides abortion services is eligible for a subgrant under this subdivision if the entity or affiliate provides abortion services solely when the abortion is directly and medically necessary to save the life of the woman, provided a physician signs a certification stating the direct and medical necessity of the abortion.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 26. Minnesota Statutes 2014, section 145.925, is amended by adding a subdivision to read:

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Subd. 10. **Reporting and publication of grant and subgrant recipients.** At least once every grant cycle, a public entity that distributes funds under subdivision 1e shall provide the commissioner of health with a list of the entities that received subgrants to provide family planning services and the amount of each subgrant. At least once every grant cycle, the commissioner of health shall publish on the department's Web site a list of all the entities that received funds as a grant from the commissioner under subdivision 1d or a subgrant from a public entity under subdivision 1e, and the amount of the grant or subgrant received by each entity.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 27. Minnesota Statutes 2014, section 149A.50, subdivision 2, is amended to read:

Subd. 2. **Requirements for funeral establishment.** A funeral establishment licensed under this section must:

(1) ~~contain a~~ comply with preparation and embalming room requirements as described in section 149A.92;

(2) contain office space for making arrangements; and

(3) comply with applicable local and state building codes, zoning laws, and ordinances.

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

Sec. 28. Minnesota Statutes 2015 Supplement, section 149A.92, subdivision 1, is amended to read:

Subdivision 1. **Establishment update.** ~~(a) Notwithstanding subdivision 11, a funeral establishment with other establishment locations that uses one preparation and embalming room for all establishment locations has until July 1, 2017, to bring the other establishment locations that are not used for preparation or embalming into compliance with this section so long as the preparation and embalming room that is used complies with the minimum standards in this section.~~

~~(b) At the time that ownership of a funeral establishment changes, the physical location of the establishment changes, or the building housing the funeral establishment or business space of the establishment is remodeled the existing preparation and embalming room must be brought into compliance with the minimum standards in this section and in accordance with subdivision 11.~~

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(a) Any room used by a funeral establishment for preparation and embalming must comply with the minimum standards of this section. A funeral establishment where no preparation and embalming is performed, but which conducts viewings, visitations, and services, or which holds human remains while awaiting final disposition, need not comply with the minimum standards of this section.

(b) Each funeral establishment must have a preparation and embalming room that complies with the minimum standards of this section, except that a funeral establishment that operates branch locations need only have one compliant preparation and embalming room for all locations.

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

Sec. 23. Minnesota Statutes 2014, section 152.27, subdivision 2, is amended to read:

Subd. 2. **Commissioner duties.** (a) The commissioner shall:

(1) give notice of the program to health care practitioners in the state who are eligible to serve as health care practitioners and explain the purposes and requirements of the program;

(2) allow each health care practitioner who meets or agrees to meet the program's requirements and who requests to participate, to be included in the registry program to collect data for the patient registry;

(3) allow each health care practitioner who meets the requirements of subdivision 8, and who requests access for a permissible purpose, to have limited access to a patient's registry information;

~~(3)~~ (4) provide explanatory information and assistance to each health care practitioner in understanding the nature of therapeutic use of medical cannabis within program requirements;

~~(4)~~ (5) create and provide a certification to be used by a health care practitioner for the practitioner to certify whether a patient has been diagnosed with a qualifying medical condition and include in the certification an option for the practitioner to certify whether the patient, in the health care practitioner's medical opinion, is developmentally or physically disabled and, as a result of that disability, the patient is unable to self-administer medication or acquire medical cannabis from a distribution facility;

~~(5)~~ (6) supervise the participation of the health care practitioner in conducting patient treatment and health records reporting in a manner that ensures stringent security and record-keeping requirements and that prevents the unauthorized release of private data on individuals as defined by section 13.02;

~~(6)~~ (7) develop safety criteria for patients with a qualifying medical condition as a requirement of the patient's participation in the program, to prevent the patient from undertaking any task under the influence of medical cannabis that would constitute negligence or professional malpractice on the part of the patient; and

~~(7)~~ (8) conduct research and studies based on data from health records submitted to the registry program and submit reports on intermediate or final research results to the legislature and major scientific journals. The commissioner may contract with a third party to complete the requirements of this clause. Any reports submitted must comply with section 152.28, subdivision 2.

(b) If the commissioner wishes to add a delivery method under section 152.22, subdivision 6, or a qualifying medical condition under section 152.22, subdivision 14, the commissioner must notify the chairs and ranking minority members of the legislative policy committees having jurisdiction over health and public safety of the addition and the reasons for its addition, including any written comments received by the commissioner from the public and any guidance received from the task force on medical cannabis research, by January 15 of the year in which the commissioner wishes to make the change. The change shall be effective on August 1 of that year, unless the legislature by law provides otherwise.

Sec. 24. Minnesota Statutes 2014, section 152.27, is amended by adding a subdivision to read:

Subd. 8. **Access to registry data.** (a) Notwithstanding section 152.31, a health care practitioner may access a patient's registry information to the extent the information relates specifically to a current patient, to whom the health care practitioner is:

(1) prescribing or considering prescribing any controlled substance;

(2) providing emergency medical treatment for which access to the data may be necessary; or

(3) providing other medical treatment for which access to the data may be necessary and the patient has consented to access to the registry account information, and with the provision that the health care practitioner remains responsible for the use or misuse of data accessed by a delegated agent or employee.

(b) A health care practitioner who is authorized to access the patient registry under this subdivision may be registered to electronically access limited data in the medical cannabis patient registry. If the data is accessed electronically, the health care practitioner shall implement and maintain a comprehensive information security program that contains administrative, technical, and physical safeguards that are appropriate to the user's size and complexity, and the sensitivity of the personal information obtained. The health care practitioner shall identify reasonably foreseeable internal and external risks to the security, confidentiality, and integrity of personal information that could result in the unauthorized disclosure, misuse, or other compromise of the information and assess the sufficiency of any safeguards in place to control the risks.

Senate Language UEH2749-1

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(c) When requesting access based on patient consent, a health care practitioner shall warrant that the request:

(1) contains no information known to the provider to be false;

(2) accurately states the patient's desire to have health records disclosed or that there is specific authorization in law; and

(3) does not exceed any limits imposed by the patient in the consent.

(d) Before a health care practitioner may access the data, the commissioner shall ensure that the health care practitioner agrees to comply with paragraph (b).

(e) The commissioner shall maintain a log of all persons who access the data for a period of three years.

Sec. 25. Minnesota Statutes 2014, section 152.33, is amended by adding a subdivision to read:

Subd. 7. **Improper access to registry; criminal penalty.** In addition to any other applicable penalty in law, a person who intentionally makes a false statement or misrepresentation to gain access to the patient registry under section 152.27, subdivision 8, or otherwise accesses the patient registry under false pretenses, is guilty of a misdemeanor punishable by imprisonment for not more than 90 days or by payment of a fine of not more than $1,000, or both. The penalty is in addition to any other penalties that may apply for making a false statement, misrepresentation, or unauthorized acquisition of not public data.

Sec. 29. Minnesota Statutes 2014, section 157.15, subdivision 14, is amended to read:

Subd. 14. **Special event food stand.** "Special event food stand" means a food and beverage service establishment which is used in conjunction with celebrations and special events, and which operates ~~no more than three times annually~~ for no more than ten total days within the applicable license period.

Sec. 26. Minnesota Statutes 2014, section 327.14, subdivision 8, is amended to read:

Subd. 8. **Recreational camping area.** "Recreational camping area" means any area, whether privately or publicly owned, used on a daily, nightly, weekly, or longer basis for the accommodation of five or more tents or recreational camping vehicles free of charge or for compensation. "Recreational camping area" excludes:

(1) children's camps;

(2) industrial camps;

(3) migrant labor camps, as defined in Minnesota Statutes and state commissioner of health rules;

Sec. 30. Minnesota Statutes 2014, section 327.14, subdivision 8, is amended to read:

Subd. 8. **Recreational camping area.** "Recreational camping area" means any area, whether privately or publicly owned, used on a daily, nightly, weekly, or longer basis for the accommodation of five or more tents or recreational camping vehicles free of charge or for compensation. "Recreational camping area" excludes:

(1) children's camps;

(2) industrial camps;

(3) migrant labor camps, as defined in Minnesota Statutes and state commissioner of health rules;

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(4) United States Forest Service camps;

(5) state forest service camps;

(6) state wildlife management areas or state-owned public access areas which are restricted in use to picnicking and boat landing; ~~and~~

(7) temporary holding areas for self-contained recreational camping vehicles created by and adjacent to motor sports facilities, if the chief law enforcement officer of an affected jurisdiction determines that it is in the interest of public safety to provide a temporary holding area; and

(8) a privately owned area used for camping no more than once a year and for no longer than seven consecutive days by members of a private club where the members pay annual dues to belong to the club.

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

Sec. 27. Laws 2015, chapter 71, article 8, section 24, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective July 1, 2015, except subdivisions 4 and 5, which are effective ~~October 1, 2017~~ July 1, 2016.

Sec. 28. **CONTAMINATED PRIVATE WELLS.**

Ten priority points must be assigned by the Department of Health pursuant to Minnesota Rules, part 4720.9020, if a drinking water advisory has been issued or a special well construction area has been established by the Department of Health.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to Minnesota Rules, part 4720.9020, until the Department of Health modifies part 4720.9020.

Sec. 29. **HEALTH RISK LIMITS.**

Fifteen points must be assigned by the Department of Health pursuant to Minnesota Rules, part 4720.9020, if the department has confirmed an exceedance of a health risk limit under Minnesota Rules, parts 4717.7500 to 4717.7900, within the past 36 calendar months.

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(4) United States Forest Service camps;

(5) state forest service camps;

(6) state wildlife management areas or state-owned public access areas which are restricted in use to picnicking and boat landing; ~~and~~

(7) temporary holding areas for self-contained recreational camping vehicles created by and adjacent to motor sports facilities, if the chief law enforcement officer of an affected jurisdiction determines that it is in the interest of public safety to provide a temporary holding area; and

(8) a privately owned area used for camping no more than once a year and for no longer than seven consecutive days by members of a private club where the members pay annual dues to belong to the club.

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

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Sec. 9. Laws 2015, chapter 71, article 8, section 24, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective July 1, 2015, except subdivisions 4 and 5, which are effective ~~October 1, 2017~~ January 1, 2018.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to Minnesota Rules, part 4720.9020, until the Department of Health modifies part 4720.9020.

Sec. 30. **MEDICALLY NECESSARY CARE DEFINITION FOR HEALTH MAINTENANCE ORGANIZATIONS.**

The commissioner of health shall convene a public meeting with interested stakeholders to discuss the need for a uniform definition of medically necessary care for health maintenance organizations to utilize when determining the medical necessity, appropriateness, or efficacy of a health care service or procedure, and a uniform process for each health maintenance organization to follow when making such an initial determination or utilization review. This discussion shall exclude determinations or reviews involving enrollees covered under a public health care program administered by the commissioner of human services under Minnesota Statutes, chapter 256B or 256L.

By January 15, 2017, the commissioner shall report results of the public input and any recommendations, including draft legislation, to the chairs and ranking minority members of the legislative committees with jurisdiction over health care on the proposed uniform definition and determination process, and a process in which the commissioner may periodically review the medically necessary care determinations to ensure that the determinations made by a health maintenance organization adhere to the uniform definition and process.

Sec. 31. **PEER REVIEW DISCLOSURE.**

The commissioner of health shall consult with interested stakeholders including members of the public and family members of facility residents and make recommendations regarding when quality of care complaint investigations under Minnesota Statutes, section 62D.115, should be subject to peer review confidentiality and identifying circumstances in which peer review final determinations may be disclosed or made available to the public, notwithstanding Minnesota Statutes, section 145.64, including, but not limited to, patient safety and the parameters surrounding such disclosure. The commissioner shall submit these recommendations, including draft legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over health care and data privacy by January 15, 2017.

Sec. 32. **COST AND BENEFIT ANALYSIS; HEALTH CARE SYSTEM PROPOSALS.**

Senate Language UEH2749-1

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Subdivision 1. **Contract for analysis of proposals.** The commissioner of health shall contract with the University of Minnesota School of Public Health to conduct an analysis of the costs and benefits of three specific proposals that seek to create a health care system with increased access, greater affordability, lower costs, and improved quality of care in comparison to the current system.

Subd. 2. **Plans.** The commissioner of health, with input from the commissioners of human services and commerce, legislators, and other stakeholders, shall submit to the University of Minnesota the following proposals:

(1) a free-market insurance-based competition approach;

(2) a universal health care plan designed to meet the following principles:

(i) ensure all Minnesotans receive quality health care;

(ii) cover all necessary care, including all coverage currently required by law, complete mental health services, chemical dependency treatment, prescription drugs, medical equipment and supplies, dental care, long-term care, and home care services;

(iii) allow patients to choose their own providers; and

(iv) use premiums based on ability to pay; and

(3) a MinnesotaCare public option that would allow individuals with income above the maximum income eligibility limit established for the MinnesotaCare program the option of purchasing this public option instead of purchasing a qualified health plan through MNsure or an individual health plan offered outside of MNsure. For purposes of conducting the analysis, the MinnesotaCare public option shall include the following:

(i) individuals who qualify for advanced tax credits and cost-sharing credits under the Affordable Care Act may use the credits to purchase the MinnesotaCare public option;

(ii) enrollee premium rates shall be established at rates that are similar to the average rate paid by the state to managed care plan contractors for MinnesotaCare;

(iii) the covered benefit set shall be equal to the benefits covered under MinnesotaCare;

(iv) the same annual open enrollment period established for MNsure shall apply for this public option; and

(v) cost-sharing shall be established that maintains an actuarial value no lower than 87 percent.

The analysis of this option must include potential financial impacts on MNsure; the long-term financial stability of the MinnesotaCare program; impacts to premiums in the individual and small group insurance market; and impacts to health care provider reimbursement rates and to the financial stability of urban, rural, and safety net providers.

Subd. 3. **Proposal analysis.** (a) The analysis of each proposal must measure the impact on total public and private health care spending in Minnesota that would result from each proposal, including spending by individuals. "Total public and private health care spending" means spending on all medical care, including dental care, prescription drugs, medical equipment and supplies, complete mental health services, chemical dependency treatment, long-term care, and home care services as well as all of the costs for administering, delivering, and paying for the care. The analysis of total health care spending shall include whether there are savings or additional costs compared to the existing system due to:

(1) increased or reduced insurance, billing, underwriting, marketing, and other administrative functions;

(2) changes in access to and timely and appropriate use of medical care;

(3) availability and take-up of health insurance coverage;

(4) market-driven or negotiated prices on medical services and products, including pharmaceuticals;

(5) shortages or excess capacity of medical facilities and equipment;

(6) increased or decreased utilization; better health outcomes; and increased wellness due to prevention, early intervention, and health-promoting activities;

(7) payment reforms;

(8) coordination of care; and

(9) to the extent possible given available data and resources, non-health care impacts on state and local expenditures such as reduced out-of-home placement or crime costs due to mental health or chemical dependency coverage.

(b) To the extent possible given available data and resources, the analysis must also estimate for each proposal job losses or gains in health care and elsewhere in the economy due to implementation of the reforms.

(c) The analysis shall assume that the provisions in each proposal are not preempted by federal law or that the federal government gives a waiver to the preemption.

Subd. 4. **Report.** The commissioner shall provide a preliminary report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by March 15, 2017, and a final report by October 1, 2017. For the analyses described in subdivision 3, paragraphs (a), clause (9), and (b), a final report is due by March 15, 2018.

Sec. 32. **EXPANDING ELIGIBILITY FOR DESIGNATION AS A CRITICAL ACCESS HOSPITAL.**

(a) The commissioner of health is encouraged to contact Minnesota's federal elected officials and pursue all necessary changes to the Medicare rural hospital flexibility program established in United States Code, title 42, section 1395i-4 to expand the number of rural hospitals that are eligible for designation as a critical access hospital. In the request for program changes, the commissioner shall seek authority to designate any hospital that applies for designation as a critical access hospital if the hospital:

(1) is located in a Minnesota county that is a rural area as defined in United States Code, title 42, section 1395ww(d)(2)(D). A hospital is not required to be located 35 miles from another hospital, or 15 miles from another hospital if located in mountainous terrain or in an area with only secondary roads; and

(2) is licensed under sections 144.50 to 144.56 and is certified to participate in the Medicare program.

(b) The commissioner shall determine other eligibility criteria for which program changes should be requested, in order to expand eligibility for designation as a critical access hospital to the greatest number of rural hospitals in the state. The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance and policy by January 1, 2017, on the status of the request for program changes.

Sec. 33. **REPEALER.**

(a) Minnesota Statutes 2014, section 149A.92, subdivision 11, is repealed the day following final enactment.

(b) Minnesota Statutes 2014, section 145.925, subdivision 2, is repealed effective July 1, 2017.