Bill Summary Comparison of Health and Human Services

House File 2749, Unofficial Engrossment (UEH2749-1)
Article 26: Health Department

House File 3467, Third Engrossment (H3467-3)
Article 4: Health Department

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Section 1 (13.3805, subd. 5) classifies radon testing and mitigation data maintained by the Department of Health as private data on individuals or nonpublic data.	Identical.	**H.F. 3944, sec. 1. Radon testing and mitigation data.** Adds subd. 5 to § 13.3805. Classifies data maintained by the Health Department that identify the address of a radon testing or mitigation site and contact information for residents and residential property owners of radon testing or mitigation sites, as private data on individuals or nonpublic data.
Section 2 (13.3806, subd. 22) adds a reference in chapter 13 and the classification of data collected under the medical cannabis registry program to include registry information accessed under section 152.27, subdivision 8.	Senate only.	
Section 3 (62D.04, subd. 1) specifies that a health maintenance organization (HMO) in their application for a certificate of authority must include arrangements for an ongoing evaluation of the quality of health care that includes a peer review process.	Senate only.	
Section 4 (62D.08, subd. 3) requires HMOs to report to the Commissioner of Health data on the number of complaints received and the category of each complaint as defined by the commissioner. Requires the commissioner to define the complaint categories to be used by each HMO by July 1, 2017, and requires the HMO to use the categories beginning in calendar year 2018.	Senate only.	
Section 5 (62D.115) establishes an investigation process for quality of care complaints for HMOs. **Subdivision 1** defines quality of care complaints. **Subdivision 2** requires each HMO to develop and implement policies and procedures for the receipt,	Senate only.	

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investigation, and resolution of quality of care complaints. **Subdivision 3, paragraph (a),** requires HMOs to report quality of complaints as part of their annual report required under section 62D.08. **Paragraph (b)** requires quality of care complaints received by the HMO that meet the highest level of severity as defined by the commissioner must be reported to the commissioner within ten calendar days of receipt of the complaint. Requires the commissioner to investigate the complaint and authorizes the commissioner to contract with experts in health care or medical practice to assist in the investigation. Requires the commissioner to provide 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. Specifies that if the commissioner takes any corrective action or requires the HMO to make any corrective measures of any kind that the nature of the complaint and the action or measures taken are public data. **Paragraph (c)** requires the commissioner to forward any quality of care complaints received by a HMO or received directly from an enrollee of a HMO that involves services by a health care provider or facility to the relevant health-related licensing board or state agency, for further investigation, upon the consent of the enrollee. **Subdivision 4** specifies that an enrollee who files a quality of care complaint with the commissioner		

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involving an HMO may submit a written request to the commissioner for an external quality of review. Requires the HMO to participate in the external quality of care review and cover the cost of the review. **Subdivision 5** requires the commissioner to contract with at least three organizations to provide independent external quality of care reviews submitted for external review. Describes what the request for proposals for the contract must contain. **Subdivision 6** describes the external quality of care review process. **Subdivision 7** requires each HMO to maintain records of all quality of care complaints and their resolution and to retain those records for five years, and make them available to the commissioner upon request. Specifies that the records provided to the commissioner are confidential data on individuals or protected nonpublic data as defined in section 13.02 **Subdivision 8** specifies that this section does not apply to quality of care complaints received by a HMO from an enrollee covered under a public health care program.		
Section 6 (62J.495, subd. 4) adds to the commissioner's coordination efforts regarding health information technology: (1) providing financial and technical support to Minnesota health care providers to encourage implementation of admission, discharge and transfer alerts, care summary document exchange transactions and to evaluate the impact of health information technology on cost and quality of care; (2) providing educational resources and technical assistance to health care providers and patients related to privacy, security,	Similar. Differences are: • In clause (3), House language requires communications about available financial and technical support to include clear information about the electronic health record requirements in subdivision 1 and exceptions. Also technical differences (staff recommend House for the technical differences).	**Sec. 1. Coordination with national HIT activities.** Amends § 62J.495, subd. 4. Adds the following activities to the commissioner of health's duties to coordinate the use of health information technology: (1) providing financial and technical support to health care providers to encourage implementation of admission, discharge, and transfer alerts and care summary and document exchange transactions, and to evaluate the impact of health information technology on cost and quality of care; (2) providing educational resources

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and consent laws governing clinical health information; (3) assessing Minnesota's legal, financial, and regulatory framework for health information exchange and making recommendations to strengthen the ability of health care providers to securely exchange data in compliance with patient preferences and in a way that is efficient and financially sustainable; and (4) seeking public input on patient impact and costs associated with requirements related to patient consent requirements for the release of health records as required under the Minnesota Health Records Act.	• In clauses (4) and (5), House language includes a reference to sections 144.291 to 144.298 (Minnesota Health Records Act). • Clause (6) is Senate only; it requires the commissioner to seek public input on patient impact and costs associated with requirements for patient consent to release of health records.	and technical assistance to health care providers and patients regarding privacy, security, and consent laws governing health information; and (3) assessing the state's legal, financial, and regulatory framework for the exchange of health information, and recommending modifications to allow providers to securely exchange data in compliance with patient preferences.
Section 7 (62J.496, subd. 1) permits funds in the electronic health record system revolving account to be used for activities describes in section 62J.495, subdivision 4.	Same, except House paragraph (h), which prohibits new loans or loan guarantees from the electronic health record system revolving account after July 1, 2016, is House only.	**Sec. 2. Account establishment.** Amends § 62J.496, subd. 1. Expands the allowable uses of funds in the electronic health record system revolving account, to allow funds to be used for the commissioner of health's activities listed in section 62J.495, subdivision 4, related to coordination of health information technology activities. Provides that the commissioner will not award new loans or loan guarantees from this account after July 1, 2016.
Section 8 (62U.04, subd. 1) extends the date to July 1, 2019, in which the commissioner may use all payer claims data to analyze variations in health care cost, quality, utilization, and illness burden based on geographical areas or populations and requires the commissioner to develop a community input process to advise the commissioner on identifying high priority analysis to be conducted and creating additional public use files of summary data.	Senate only.	

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Section 9 (144.061) requires the commissioner as part of the incentive pilots for the early dental prevention initiative passed last year to designate up to three communities of color or of recent immigrants and work with these communities to ensure that the educational materials and information are effectively distributed within these communities, and then evaluate the strategies used to determine whether the strategies increased the numbers of infants and toddlers receiving early preventive dental care.	Senate only.	
Section 10 (144.0615) requires the commissioner to develop a statewide coordinated dental sealant program to improve access to preventive dental services for school-aged children. The commissioner shall award grants to nonprofit organizations to provide the school-based programs and report to the legislature by March 15, 2018, on the implementation of the program, data tools developed, outcome measures, grants awarded and location, and the evaluation results.	Senate only.	
Section 11 (144.1912) requires the commissioner to award family medicine residency grants to existing, not-for-profit family medicine residency programs located outside the seven-county metropolitan area to support current and new residency positions. The commissioner may fund a new residency position for up to three years. Describes what the grant funds may be used for and requires the commissioner to collect the necessary information from the residency programs to implement and evaluate the program.	Subd. 1: one technical difference (staff recommend Senate) Subds. 2 and 3: identical Subd. 4: • Senate requires the commissioner to collect data to administer the program, House permits it. • Senate specifies what the program evaluation must include and also requires data to continue to be collected on greater Minnesota family residency shortages.	**Sec. 3. Greater Minnesota family medicine residency grant program.** Adds § 144.1912. Creates a program administered by the commissioner of health to award grants to family medicine residency programs that are located outside the seven-county metro area and that have a demonstrated history of training physicians for practice outside the metro area. **Subd. 1. Definitions.** Defines terms "commissioner" and "eligible family medicine residency program." **Subd. 2. Program administration.** Directs the commissioner to award grants to existing, eligible, nonprofit family medicine residency programs to fund

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	• One technical difference (staff recommend Senate).	new and existing residency positions. Requires funds to be allocated first for new residency positions, with remaining funds allocated for existing positions. Allows the commissioner to fund a new residency position for up to three years, lists allowable uses for grant funds, and prohibits funds from supplanting other funds available for residency positions. **Subd. 3. Applications.** Establishes a process for programs to apply for grant funds. **Subd. 4. Program oversight.** Allows the commissioner to collect information from residency programs that the commissioner needs to administer and evaluate the grant program.
	House only.	**Sec. 4. Patient consent to release of records.** Amends § 144.293, subd. 2. Requires a consent form used by a health care provider for the release of a patient's health records to include the option to indicate yes or no to each type of health records release for which the provider is requesting consent. Prohibits a provider from conditioning the patient's receipt of treatment on the patient's willingness to release records.
Section 12 (144.4961, subd. 3) clarifies the rulemaking authority of the commissioner for establishing licensure requirements and work standards relating to indoor radon in dwellings and other buildings.	Identical.	**H.F. 3944, sec. 2. Rulemaking.** Amends § 144.4961, subd. 3. Clarifies the authority of the commissioner of health to adopt rules to establish licensure requirements and work standards for indoor radon in dwellings and other buildings. **Effective date.** Makes this section effective the day following final enactment.

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Section 13 (144.4961, subd. 4) modifies the date in which radon mitigation systems installed must have a radon mitigation system tag provided by the commissioner from October 1, 2017, to January 1, 2018.	Same, except House has section effective date of 1-1-18. (Section effective date not necessary with effective date also in section text; staff recommend Senate.)	**H.F. 3944, sec. 3. System tag.** Amends § 144.4961, subd. 4. Requires radon mitigation systems installed on or after January 1, 2018, to have radon mitigation tags provided by the commissioner of health (current law requires radon mitigation tags for systems installed on or after October 1, 2017).
Section 14 (144.4961, subd. 5) modifies the effective date requiring licensure for persons performing laboratory analysis, or performs a service to mitigate radon in the indoor atmosphere, from October 1, 2017, to January 1, 2018. Removes the licensure requirement for persons that sell devices that detect the presence of radon in the indoor atmosphere.	Same except Senate inserts effective date in text of section and House places effective date in an effective date section (staff recommend Senate).	**H.F. 3944, sec 4. License required annually.** Amends § 144.4961, subd. 5. Modifies the services for which radon licensure is required, to not require licensure for persons, firms or corporations that sell devices to detect radon indoors. Also removes an exemption for retail stores that is no longer needed, since licensure is no longer required for entities that sell radon detection devices. Makes this section effective July 1, 2018.
Section 15 (144.4961, subd. 6) specifies that licensure does not apply to radon control systems installed in newly constructed Minnesota homes, employees of a firm or corporation that installs radon control systems in newly constructed Minnesota homes; a person authorized as a building official; or any person that distributes radon testing devices or information for general education purposes.	Same, except for technical difference in clause (3) (staff recommend Senate).	**H.F. 3944, sec. 5. Exemptions.** Amends § 144.4961, subd. 6. Exempts the following from licensure requirements for radon testing and mitigation professionals and firms: • employees of a firm or corporation that installs radon control systems in newly constructed Minnesota homes; • building officials that enforce the Building Code or their designees; and • persons and entities that distribute radon testing devices or information for educational purposes. **Effective date.** Makes this section effective the day following final enactment.

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Section 16 (144.4961, subd. 8) modifies the fees for radon licenses.	Identical.	**H.F. 3944, sec. 6. Licensing fees.** Amends § 144.4961, subd. 8. Modifies radon licensure fees for measurement professionals, mitigation professionals, and mitigation companies. Specifies that employees or subcontractors supervised by a licensed mitigation professional are not required to be licensed. Waives the license fee for mitigation companies that employ only one licensed mitigation professional. Makes this section effective the day following final enactment.
Section 17 (144.4961, subd. 10) specifies that the Radon Licensing Act does not preclude local units of government from requiring additional permits or inspections for radon control systems and does not supersede local inspection or permit requirements.	Identical.	**H.F. 3944, sec. 7. Local inspections or permits.** Adds subd. 10 to § 144.4961. Specifies that the section on radon licensure does not preclude local units of government from requiring additional permits or inspections for radon control systems. Makes this section effective the day following final enactment.
	House only.	**H.F. 3944, sec. 8. Application; newly constructed homes.** Adds subd. 11 to § 144.4961. Specifies that section 144.4961 does not apply to newly constructed Minnesota homes prior to issuance of a certificate of occupancy.
	House only.	**Sec. 5. Prescription drug price reporting.** Adds § 144.7011. **Subd. 1. Definitions.** Defines the following terms: available discount, retail pharmacy, and retail price. **Subd. 2. Prescription drug price information reporting.** Requires the commissioner of health, by July 1, 2017, to establish an online, interactive Web site

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		that allows retail pharmacies to voluntarily list retail prices and available discounts for one or more of the 150 mostly commonly dispensed prescription drugs. Specifies criteria for the Web site. Requires the commissioner of health to annually consult with the commissioner of human services to determine the 150 most commonly filled drugs, based on MA and MinnesotaCare drug utilization. **Subd. 3. Pharmacy duties.** Beginning July 1, 2017, and each month thereafter, requires participating pharmacies to submit retail prices and available discounts to the commissioner. Requires pharmacies to provide 60-days' notice when opting out of the reporting system. **Subd. 4. External vendors.** Allows the commissioner to contract with an outside vendor to collect data from pharmacies, and to develop and host the interactive application.
	House only.	**Sec. 6. Exclusions from home care licensure.** Amends § 144A.471, subd. 9. This subdivision lists individuals and organizations that are excluded from requirements that apply to licensed home care providers, when the excluded individuals and organizations provide specific home care services. • The amendment to clause (10) adds employees of licensed home care providers to the list of employees that are excluded from requirements that apply to licensed home care providers, when the employees of licensed home care providers respond to occasional emergency calls from individuals who live in settings

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		attached to or next to the location where home care services are also provided. • The new clause (11) excludes employees of nursing homes, home care providers, and boarding care homes from requirements that apply to licensed home care providers, when the employees provide occasional minor services free of charge to individuals who live in settings attached to or next to the nursing home, boarding care home, or location where home care services are also provided.
Section 18 (144A.75, subdivision 5) removes from the definition of "hospice provider" the condition that a hospice patient must be terminally ill.	Identical.	**Sec. 7. Hospice provider.** Amends section 144A.75, subd. 5. Removes a reference to "terminally ill" from the definition of "hospice provider" to conform with changes made to the definition of "hospice patient" in section 144A.75, subdivision 6.
Section 19 (144A.75, subdivision 6) expands the definition of "hospice patient" to include a person, 21 years of age or younger, who has been diagnosed with a life-threatening illness that contributes to a shortened life expectancy.	Same, except clause (2): • Senate describes illness as life-threatening, House describes illness as chronic, complex, and life-threatening. • House specifies that the person is not expected to survive to adulthood.	**Sec. 8. Hospice patient.** Amends § 144A.75, subd. 6. Expands the definition of "hospice patient" to include an individual who is age 21 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. Adding these patients to the definition allows them to receive services from a hospice provider.
Section 20 (144A.75, subdivision 8) modifies the definition of "hospice services" to allow currently existing hospice services to be provided to patients who fall under the newly expanded definition of "hospice patient."	Differences conform with the differences in the definition of hospice patient. Senate also strikes a reference to "terminally ill." House also includes a reference to the new portion of the definition of hospice patient.	**Sec. 9. Hospice services; hospice care.** Amends § 144A.75, subd. 8. Amends the definition of "hospice services" or "hospice care" to conform with changes made to the definition of "hospice patient."

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Section 21 (144A.75, subdivision 13) modifies the definition of "residential hospice facility" by clarifying that a residential hospice facility must meet existing setting requirements concerning life safety, accessibility, and the care needs of hospice patients.	Identical.	**Sec. 10. Residential hospice facility.** Amends § 144A.75, subd. 13. Amends the definition of "residential hospice facility" to clarify that the facility resembles a single-family home that has been modified to address life safety, accessibility, and care needs.
Section 22 (144A.75, subdivision 13a) adds a definition for "respite care" to clarify that residential hospice facilities may provide respite services on an occasional basis to hospice patients and their caregivers, including to patients included under the newly expanded definition of "hospice patient."	Same except for one punctuation difference (staff recommend Senate).	**Sec. 11. Respite care.** Adds subd. 13a to § 144A.75. Adds a definition of "respite care." This definition is similar to the definition of respite care found in hospice services rules at Minnesota Rules, part 4664.0020, subpart 5, except the definition in this bill includes a reference to residential hospice facility.
	House only.	**Sec. 12. Forms.** Amends § 145.4131, subd. 1. Requires a physician or facility performing an abortion to include in abortion data reports submitted to the commissioner of health, the facility code for the patient and the facility code for the physician, if the abortion was performed via telemedicine. This section is effective January 1, 2017.
	House only.	**Sec. 13. Licensure of certain facilities that perform abortions.** Adds § 145.417. **Subd. 1. License required for facilities that perform ten or more abortions per month.** (a) Requires facilities where ten or more abortions are performed per month to be licensed by the commissioner of health and subject to licensure requirements under Minnesota Rules, chapter 4675 (outpatient surgical centers). Exempts hospitals and outpatient surgical centers from having to obtain a separate license.

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		(b) Allows certain parties to seek an injunction against the continued operation of an unlicensed facility. (c) States that sanctions under other sections of law are allowed in addition to this subdivision. **Subd. 2. Inspections; no notice required.** Requires the commissioner to perform routine and comprehensive inspections and investigations of facilities described in subdivision 1, not more than two times per year. Allows the inspection to be without notice and requires the facility to be open at all reasonable times for inspection. **Subd. 3. Licensure fee.** Requires facilities to pay an annual license fee of $3,712 to be collected by the commissioner of health and deposited according to section 144.122 (general licensing fees and deposits statute). **Subd. 4. Suspension, revocation, and refusal to renew.** Allows the commissioner to refuse to grant or renew licenses, and allows suspension and revocation of licenses for the following grounds: (1) violating Minnesota Rules, chapter 4675 (outpatient surgical centers); (2) permitting, aiding, or abetting an 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) a pattern of conduct involving one or more physicians in the facility who have a financial or economic interest in the facility and have not provided notice and disclosure of that interest. **Subd. 5. Hearing.** Requires a hearing be provided to a facility prior to any suspension, revocation, or refusal to renew a license. Puts the burden of proof of a violation on the commissioner and allows a new license application to be filed if the conditions upon which the revocation, suspension, or refusal to renew are based are corrected. Granting of the new license is conditional upon inspection for compliance with this section and Minnesota Rules, chapter 4657. **Subd. 6. Severability.** Allows for severability of any provision of this section if a provision is found to be unconstitutional.
	House only.	**Sec. 16. Allocation to commissioner of health.** Amends section 145.882, subdivision 2. Effective July 1, 2017, requires any maternal and child health (MCH) block grant funds retained by the commissioner of health and used for grants for prepregnancy family planning services to be distributed according to section 145.925 (family planning grants).
	House only.	**Sec. 17. Allocation to community health boards.** Amends section 145.882, subdivision 3. Effective July 1, 2017, amends a subdivision allocating MCH block grant funds to community health boards, to require MCH block grant funding allocated to community health boards and used for prepregnancy family planning services to be distributed according to section 145.925.

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	House only.	**Sec. 18. Use of block grant money.** Amends section 145.882, subdivision 7. Effective July 1, 2017, adds a cross-reference to a subdivision listing allowable uses of MCH block grant money that is allocated to community health boards to include MCH funds distributed according to section 145.925.
	House only.	**Sec. 19. Grant program; screening and treatment for pre- and postpartum mood and anxiety disorders.** Adds § 145.908. Directs the commissioner of health to establish a grant program, within the limits of federal funds available specifically for this purpose, to provide culturally competent screening and treatment for pre- and postpartum mood and anxiety disorders in pregnant women and women who have given birth in the last 12 months. **Subd. 1. Grant program established.** Directs the commissioner of health to establish the grant program. Allows organizations to use grant funds to establish new programs, or to expand or maintain existing programs. Requires the commissioner to prioritize funding screenings in primary care settings. **Subd. 2. Allowable uses of funds.** Lists required and permitted uses of funds. **Subd. 3. Federal funds.** Requires the commissioner to apply for any available federal grant funds for the program.

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	House only.	**Sec. 20. Purpose.** Amends § 145.925, subdivision 1. Current law allows the commissioner of health to make grants to the listed entities to provide prepregnancy family planning services. Effective July 1, 2017, this section requires the commissioner to make grants for family planning services; the list of entities eligible for grants is moved to subdivisions 1d and 1e in section 145.925.
	House only.	**Sec. 21. Definitions.** Amends § 145.925, subdivision 1a. Effective July 1, 2017, adds definitions for the following terms: community health board, family planning, federally qualified health center, hospital, public health clinic, and rural health clinic.
	House only.	**Sec. 22. Commissioner to apply for federal Title X funds.** Adds subdivision 1b to § 145.925. Requires the commissioner of health to apply for federal Title X funds in each grant cycle, beginning with the federal 2018 grant cycle. (Title X is a federal grant program administered by the Department of Health and Human Services, Office of Population Affairs, to fund family planning and related preventive health services to low-income individuals.)
	House only.	**Sec. 23. State and federal funds distributed according to this section.** Adds subdivision 1c to § 145.925. Effective July 1, 2017, requires the commissioner to distribute the following funds according to this section: federal Title X funds received by the commissioner of health; money appropriated from the general fund or the federal TANF fund for family planning grants under this section; and MCH block grant money used for prepregnancy family planning services.

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	House only.	**Sec. 24. Distribution; eligible entities.** Adds subdivision 1d to § 145.925. Effective July 1, 2017, requires the commissioner to distribute funds as follows: • The commissioner shall distribute funds to public entities, including community health boards and public health clinics, that apply to the commissioner. • If any funds remain after the commissioner fulfills grant requests from public entities, the commissioner may distribute the remaining funds to hospitals, federally qualified health centers, and rural health clinics that provide comprehensive primary and preventive health care services and that apply to the commissioner for funds.
	House only.	**Sec. 25. Subgrants from public entities.** Adds subdivision 1e to § 145.925. Effective July 1, 2017, allows a public entity that receives funds under subdivision 1d to distribute funds to other public or private entities to provide family planning services. Prohibits an entity from receiving a subgrant under this section if the entity provides abortion services or has an affiliate that provides abortion services, unless the entity or affiliate provides abortion services solely when the abortion is directly and medically necessary to save the life of the woman.

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	House only.	**Sec. 26. Reporting and publication of grant and subgrant recipients.** Adds subd. 10 to section 145.925. Effective July 1, 2017, requires public entities to report to the commissioner each grant cycle on subgrant recipients and subgrant amounts. Also requires the commissioner to publish a list of all grant and subgrant recipients and grant and subgrant amounts on the department's Web site.
	House only.	**Sec. 27. Requirements for funeral establishment.** Amends § 149A.50, subd. 2. Makes a change to requirements for funeral establishments to conform with changes made to section 149A.92, which governs preparation and embalming rooms.
	House only.	**Sec. 28. Establishment update.** Amends § 149A.92, subd. 1. Removes a requirement that all funeral establishments must, by July 1, 2017, contain a preparation and embalming room that complies with the standards in this section. Instead, requires a room used by a funeral establishment for preparation and embalming to comply with the standards in this section, and allows a funeral establishment with branch locations to have one prep and embalming room that complies with the standards in this section for all locations. Specifies a funeral establishment where no preparation and embalming is performed does not need to have an on-site prep and embalming room.
Section 23 (152.27, subd. 2) permits health care practitioners who meet certain requirements and who request access for a permissible purpose to have limited access to a patient's registry information in the medical cannabis registry program.	Senate only.	
Section 24 (152.27, subd. 8) paragraph (a) authorizes a health care practitioner to access a patient's registry	Senate only.	

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information in the medical cannabis registry program to the extent the information relates to a current patient for whom the health care practitioner is (1) prescribing or considering prescribing a controlled substance; (2) providing emergency medical treatment for which 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 information and with the condition that the practitioner remains responsible for the use or misuse of the data. **Paragraph (b)** authorizes a practitioner who is authorized to access the patient registry to electronically access the data. Requires the practitioner to implement and maintain a comprehensive information security program that contains appropriate safeguards. **Paragraph (c)** states that if the practitioner is accessing the data on a patient's consent the practitioner must warrant that the request (1) contains no information known to the practitioner 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. **Paragraph (d)** requires the commissioner to ensure that before a health care practitioner accesses the data, that the practitioner agrees to comply with the requirements of paragraph (b). **Paragraph (e)** requires the commissioner to maintain a log of all persons who access the data for a period of three years.		

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Section 25 (152.33, subd. 7) states that any person who intentionally makes a false statement or misrepresentation to gain access to the patient registry or otherwise accesses the patient registry under false pretenses is guilty of a misdemeanor.	Senate only.	
	House only.	**Sec. 29. Special event food stand.** Amends § 157.15, subd. 14. In a chapter governing food, beverage, and lodging establishments, amends the definition of special event food stand by removing a requirement that the special event food stand could operate no more than three times a year. With this amendment, a special event food stand may operate no more than ten total days within the applicable license period for the food stand.
Section 26 (327.14, subd. 8) excludes from the definition of "recreational camping area" a privately owned area used for camping no more than once a year for no longer than seven consecutive days by members of a private club. This would exclude this camping area from the regulations of chapter 327.	Identical.	**Sec. 30. Recreational camping area.** Amends § 327.14, subd. 9. In a chapter on regulation of camping areas by the commissioner of health, amends the definition of recreational camping area to exclude the following from Health Department regulation and fees: a privately owned camping area used for no more than once a year for no longer than seven days in a row by members of a private club who pays dues. **Effective date.** This section is effective the day following final enactment.
Section 27 amends the effective date for licensure of radon control systems.	Senate effective date is 7-1-16; House effective date is 1-1-18. (Staff recommend Senate to conform with effective dates in Senate sections 13 and 14.)	**H.F. 3944, sec. 9. Effective date.** Modifies the effective date for provisions requiring radon mitigation system tags and licensure of radon firms and professionals.

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Section 28 requires ten priority points to be assigned by the Department of Health for purposes of contaminated private wells for purposes of applying for grants and loans from the Drinking Water Revolving Fund.	Senate only.	
Section 29 requires 15 points to be assigned by the Department of Health for the purpose of health risk limits for purposes of applying for grants and loans from the Drinking Water Revolving Fund.	Senate only.	
Section 30 requires the Commissioner of Health to convene a public meeting of interested stakeholders to discuss the need for a uniform definition of medical necessary care for Health Maintenance Organizations (HMOs) to utilize when determining the medical necessity, appropriateness, or efficacy of a health care service or procedure and a uniform process for each HMO to follow when making an initial determination or utilization review. The commissioner shall report the results of the public input and any recommendations to the legislature by January 15, 2017.	Senate only.	
Section 31 requires the Commissioner of Health, in consultation with stakeholders and members of the public and family members of facility residents, to make recommendations regarding when quality of care complaint investigations 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. The commissioner shall report these recommendations to the legislature by January 15, 2017.	Senate only.	

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Section 32 requires the Commissioner of Health to 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. The proposals to be analyzed are: (1) a free market insurance-based competition approach; (2) a universal health care plan; and (3) a MinnesotaCare public option. Requires the commissioner to report the results to the legislature by October 1, 2017.	Senate only.	
	House only.	**Sec. 32. Expanding eligibility for designation as a critical access hospital.** Encourages the commissioner of health to contact Minnesota's federal elected officials and pursue changes to the Medicare rural hospital flexibility program to expand the number of hospitals eligible for designation as a critical access hospital. Requires a status report to legislative committees by January 1, 2017.
	House only.	**Sec. 33. Repealer.** Paragraph (a), repeals section 149A.92, subdivision 11, the day following final enactment. This subdivision specifies that all funeral establishments where human remains are present for preparation and embalming, viewings, visitations, services, and holding must comply with the requirements for preparation and embalming rooms. Paragraph (b) repeals section 145.925, subdivision 2, effective July 1, 2017. This subdivisions prohibits the commissioner from making family planning grants to nonprofit corporations that perform abortions, excluding hospitals and health maintenance organizations.