Bill Summary Comparison of Health and Human Services

Senate: H.F. 2749, First Unofficial Engrossment

and

House: H.F. 3467, Third Engrossment

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Section 1 (119B.13, subd. 1) increases the child care provider rate. Beginning January 2, 2017, the rate for child care assistance is the rate in effect February 3, 2014, increased by 7 percent.	Different. The Senate increases maximum provider reimbursement rates by seven percent beginning January 2, 2017. The House modifies maximum provider reimbursement rates for providers located in cities that are located inside two or more counties, setting the maximum rate at the rate paid in the county with the highest maximum reimbursement rates.	**Section 1. Subsidy restrictions.** Amends § 119B.13, subd. 1. Modifies child care assistance program maximum rates by setting the maximum rate for child care providers who are located within the boundaries of a city located in two or more counties at the maximum rate paid in the county with the highest maximum reimbursement rates or the provider's charge, whichever is less. **Effective date.** Provides an effective date of September 11, 2017.
Section 2 (145.4716, subd. 2) makes a technical modification to the safe harbor statute by adding a cross-reference to Minnesota Statutes, section 609.3241.	Identical.	**Art. 4, sec. 14. Duties of director.** Amends § 145.4716, subd. 2. Directs the director of child sex trafficking prevention at the Minnesota Department of Health to manage the program in section 609.3241 that distributes funds to crime victims services organizations to serve sexually exploited youth. (Under current law this grant program is managed by the commissioner of public safety.)
Section 3 (**145.4716, subd. 3)** expands eligibility for the safe harbor services and housing to youth 24 years of age or younger, consistent with the Homeless Youth Act under chapter 256K and related federal law.	Identical.	**Art. 4, sec. 15. Youth eligible for services.** Amends § 145.4716, by adding subd. 3. Specifies that youth age 24 and younger are eligible for safe harbor services provided by the commissioner of health and for shelter, housing beds, and services provided by the commissioner of human services for sexually exploited youth and youth at risk of sexual exploitation. (Currently these services are provided to youth age 18 and younger.)

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	House only section.	**Sec. 2. Electronic application; information.** Creates § 245A.043. Paragraph (a) instructs the commissioner to study the cost for development of a Web site for use by child care providers and prospective providers that would provide a single point of access for statutes and rules relevant to child care; a guide how to start a child care business; and completing and submitting electronic applications, child care assistance program registration, application for rating under the quality rating and improvement system, among other things. Paragraph (b) instructs the commissioner to submit the feasibility study to the legislature by September 30, 2016. Provides an immediate effective date.
	House only section.	**Sec. 3. Notification to provider.** Creates § 245A.055. Paragraph (a) requires a county licensor who has conducted a licensing inspection to provide the licensee with written notification of potential licensing violations noted during the visit. The notification must be provided prior to the licensor's departure from the home. Paragraph (b) clarifies that by issuing the required notification to the licensee, the licensor is not relieved from notifying the commissioner of the violation as required by statute or rule.

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Sections 4 to 15 (245A.10, subd. 2, 245C.03, subd. 6a, 245C.04, subd. 1, 245C.05, subd. 2b, 245C.05, subd. 4, 245C.05, subd. 7, 245C.08, subd. 1, 245C.08, subd. 2, 245C.08, subd. 4, 245C.11, subd. 3, 245C.17, subd. 6, 245C.23, subd. 2) amend the Department of Human Services (DHS) Licensing Act and DHS Background Study Act, by transferring the responsibility to perform background studies on family child care and legal nonlicensed child care providers from the county to DHS.	Senate only sections.	
	House only section.	**Sec. 4. Positive support strategies.** Creates § 245A.23. Paragraph (a) requires the commissioner to review and evaluate the applicability of the positive support strategies and restrictive intervention rules to child care providers. Lists items the commissioner must consider. Requires the commissioner to complete this review and evaluation process no later than December 31, 2016, and to submit a written plan to modify application of rules for child care programs to the legislature by January 15, 2017. Paragraph (b) exempts child care providers from certain rules until the commissioner has completed the review and evaluation process and submitted a written plan to the legislature. Provides and immediate effective date.

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	House only section.	**Sec. 5. Training for county licensing staff on family child care and group family child care requirements; supervision.** Creates § 245A.55. Paragraph (a) establishes an eight-hour preservice training requirement for county licensors. Paragraph (b) requires the commissioner to increase training and oversight of county licensors. Requires the commissioner to conduct at least biennial reviews of county performance. Paragraph (c) instructs the commissioner to provide notices annually to county licensors and their supervisors on new laws relating to family child care and group family child care that were enacted during the previous 12 months.
Article 6, section 27 [Food Stamp Employment and Training] makes participation in employment and training services optional, rather than mandatory, which is a federal option for all states. Eligible participants are allowed three months of SNAP benefits in three years, unless they are meeting federal work participation standards.	See Senate article 6, section 27 (Equity). Subds. 1, 1a, 2, 2a, 3, 3a, 3b, 6c, 7, 8, 9, and 18 are Senate only. Subd. 6b is similar. The Senate limits the amount of administrative costs to 10 percent of the funds and the House does not. The Senate specifies federal financial participation must be paid at a rate to be determined by DHS and DEED and the House does not. Other technical and stylistic differences.	**Sec. 6. Federal reimbursement.** Amends § 256D.051, subd. 6b. Adds language to the Food Stamp Employment and Training Program statute specifying how the federal appropriation for the program must be used. Requires the commissioner to report, by February 15, 2017, to the legislative committees with jurisdiction over the food stamp program on the progress of securing additional federal reimbursement funds. Allows service providers to be paid with federal funds for Food Stamp employment and training costs they incur.
Section 16 (256M.41, subd. 3) amends the child protection payment formula to counties to retain the existing formula. This section also changes the month the commissioner makes threshold determinations and the month that payments are sent to counties.	Senate only section.	

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Section 17 (256N.26, subd. 3) increases the basic monthly rate for Northstar Care for Children by 15 percent.	Senate only section.	
Section 18 (256P.06, subd. 3) clarifies that income includes all child support that the assistance unit receives, not just current support.	Senate only section.	
Section 19 (260C.125) creates a new section of law establishing the procedure for transferring the responsibility for the placement and care of an Indian child in out-of-home placement from the social services agency to a tribal agency.	Senate only section.	
Section 20 (260C.203) strikes language that is consolidated in a new section of law, section 260C.452.	Senate only section.	
Section 21 (260C.212, subd. 1) allows a child 14 years or older to select one member of the case planning team to be designated as the child's adviser and to advocate for reasonable and prudent parenting standards. For a child 18 years or older, this section requires, when appropriate, that the social services agency involve the child's parents in the child's case planning. This section also provides more detail related to educational stability requirements for foster children, clarifies the child's role in the development of the independent living plan, and requires that the child receives notice of rights.	Senate only section.	
Section 22 (260C.212, subd. 14) defines the term "developmentally appropriate," and modifies the definition of "reasonable and prudent parenting." This section also requires the commissioner to provide guidance as to what activities a foster parent must consider when applying reasonable and prudent standards.	Senate only section.	

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Section 23 (260C.215, subd. 4) requires the curriculum for foster parents to include, as necessary, knowledge and skills related to reasonable and prudent parenting standards.	Senate only section.	
Section 24 (260C.451, subd. 6) clarifies that a child may reenter foster care prior to 21 years of age.	Senate only section.	
Section 25 (260C.451, subd. 9) adds a new subdivision clarifying requirements of administrative or court reviews to ensure the social services agency is making reasonable efforts to finalize the permanency plan for the child.	Senate only section.	
Section 26 (260C.452) creates a new section of law consolidating provisions related to the successful transition to adulthood for children under the guardianship of the commissioner, which includes independent living plan, notification of right to continued access to services, administrative or court review of placements, and notification of termination of foster care.	Senate only section.	
Section 27 (260C.521, subd. 1) modifies the purpose of the court review hearing of an order for permanent custody by specifying requirements of the responsible social services agency.	Senate only section.	
Section 28 (260D.14) amends the chapter of law related to a child in voluntary foster care for treatment chapter of law, by creating a new section related to the successful transition to adulthood, which includes case planning, notification of continued right to access services, and administrate or court reviews.	Senate only section.	

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Section 29 (518.175, subd. 5) amends the statute governing modification of parenting time to provide that if a parenting plan or parenting time order cannot be used to determine the number of overnights a child has with each parent, the court must modify the plan or order so that the amount may be determined for purposes of the statute governing the parenting expense adjustment.	Identical.	**Sec. 7. Modification of parenting plan or order for parenting time.** Amends § 518.175, subd. 5. Makes structural changes to the subdivision. Instructs the court to modify an existing parenting plan or court order, if the plan or order cannot be used to determine the number of overnights or overnight equivalents the child has with each parent, so that the number of overnights or overnight equivalents the child has with each parent can be determined. Provides an August 1, 2018, effective date.
Section 30 (518A.26, subd. 14) amends the definition of "obligor" to provide that if a parent has more than 55 percent court-ordered parenting time, there is a rebuttable presumption that the parent has a zero dollar basic support obligation. Factors to be considered overcoming this presumption are specified. It does not eliminate an obligation to pay child support arrears or apply in cases where the public authority is bringing an action for contribution by a parent.	Substantially similar. Senate specifies that a zero dollar support obligation does not eliminate an obligor's arrears obligation or in cases in which the public authority is bringing a child support or paternity action. Staff recommends Senate.	**Sec. 8. Obligor.** Amends Minnesota Statutes 2015 Supplement, § 518A.26, subd. 14. To the definition of obligor, new language is added to provide that if a parent has more than 55 percent parenting time, there is a rebuttable presumption that the parent will have a zero dollar basic support obligation. Lists the types of evidence that can be produced to overcome the presumption. Adds that a zero support obligation does not relieve a party from paying arrears. Provides an August 1, 2018, effective date.
Section 31 (518A.34) modifies the parenting expense adjustment to the basic support obligation, consistent with other amendments in the bill. New provisions are included governing calculations in cases where parents have split custody of joint children. Parallel provisions are included for purposes of the basic support obligation, child care support obligation, and medical support.	Identical except for two technical differences. Staff recommends Senate.	**Sec. 9. Computation of child support obligations.** Amends § 518A.34. Makes technical changes to conform with the changes made to the parenting expense adjustment formula in section 518A.36. Adds a new paragraph to establish the method of determining child support obligations when parents have split custody of joint children. Provides an August 1, 2018, effective date.

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Section 32 (518A.35, subd. 1) provides that unless a parent has court-ordered parenting time, the parenting expense adjustment formula must not be applied. Special provisions are included in cases where a support order is sought by the public authority.	Senate only section. (This is technical, allows counties to continue to pursue support orders, and is supported by all parties.) Staff recommends Senate.	
Section 33 (518A.36) contains the operative language governing changes in the parenting expense adjustment. **Subdivision 1** requires the percentage of time in a calendar year that a child is scheduled to spend with the parent to be calculated based on a two-year average. Language governing the use of overnight equivalents for purposes of calculating the percentage of parenting time is included. **Subdivision 2** contains the new formula for the calculation of the parenting expense adjustment. **Subdivision 3** strikes language applicable in cases where parenting time is equal, which is replaced by new provisions in **subdivision 2**.	Identical except for formatting differences. Staff recommends House.	**Sec. 10. Parenting expense adjustment.** Amends § 518A.36. **Subd. 1. General.** Adds that parenting time means the percentage of time a child spends with a parent during a calendar year according to a court order and averaged over a two year period. **Subd. 2. Calculation of parenting expense adjustment.** Establishes a new formula for determining the parenting expense adjustment. **Subd. 3. Calculation of basic support when parenting time is equal.** Strikes language made obsolete by the new parenting expense adjustment. Provides an August 1, 2018, effective date.

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Section 34 (518A.39, subd. 2) amends the law governing modification of maintenance or support orders. Special provisions are included for cases where child support was established by applying a parenting expense adjustment under prior law where there is no parenting plan or order from which overnights may be determined. A formula is included for determining an obligation under previously existing child support guidelines. Changes are made in the modification language applicable when child support guidelines are amended and application of the change would result in a hardship.	Identical except for paragraph (k). When new guidelines are implemented, if a modification of support based on those guidelines would cause a hardship, the modification may be limited. The Senate adds that eligibility for assistance under chapter 256J may be considered a hardship for purposes of this paragraph. Staff recommends Senate. (The Senate language is technical and is supported by all parties.)	**Sec. 11. Modification.** Amends Minnesota Statutes 2015 Supplement, § 518A.39, subd. 2. Adds that if child support was established by applying a parenting expense adjustment under previously existing child support guidelines and there is no parenting plan or order from which overnights or overnight equivalents can be determined, then there is a rebuttable presumption that the established child support obligation will continue after modification unless the modification is based on a change in parenting time. Makes a technical change to reference the amended child support guidelines. Provides an August 1, 2018, effective date.
	House only section.	**Sec. 12. Child Support Task Force.** Creates § 518A.79. Creates the Child Support Task force to advise the commissioner of human services on matters related to the child support guidelines. Instructs the commissioner to prepare a legislative report on task force activities, issues identified by the task force and recommendations for legislative actions. Requires the first report to be submitted February 15, 2018. Provides that the task force expires June 30, 2019, unless extended by the legislature. Provides an immediate effective date.

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Section 35 (609.3241) amends chapter 609, which is the criminal code, related to the assessment imposed due to a conviction under 609.322 (Solicitation, Inducement, and Promotion of Prostitution; Sex Trafficking) and 609.324 (Patrons; Prostitutes; Housing Individuals Engaged in Prostitution; Penalties), by changing the assessment formula; the assessment that is currently forwarded to the Commissioner of Public Safety, and deposited in the safe harbor for youth account in the special revenue fund, will instead be forwarded to the Commissioner of Health.	Identical.	**Art. 4, § 31. Penalty assessment authorized.** Amends § 609.3241. Transfers management of the program to distribute funds to crime victims services organizations to serve sexually exploited youth, from the commissioner of public safety to the commissioner of health.
Section 36 (626.556, subd. 2) amends the definition of sexual abuse in the Maltreatment of Minors Act. Effective May 29, 2017, the term sexual abuse includes a child who is a victim of sex trafficking.	Senate only section.	
Section 37 (626.556, subd. 3c) Paragraph (b) requires the Department of Human Services (DHS) to investigate maltreatment in foster homes that are monitored by private agencies, and foster homes monitored by the county, upon agreement by the county and DHS. This section also, in new paragraph (c), requires the Department of Human Services to investigate the death of a child in a foster care program.	Senate only section.	
Section 38 (626.556, subd. 3e) provides that the local welfare agency is responsible for investigating when a child is identified as a victim of sex trafficking, effective May 29, 2017.	Senate only section.	
Section 39 (626.556, subd. 10b) requires the Commissioner of Human Services to investigate every incident involving the	Senate only section.	

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death of a child during placement in a licensed child foster care home.		
Section 40 (626.556, subd. 10f) makes a conforming change, resulting from changes in a previous section shifting the responsibility for maltreatment investigations of private agencies from the county to the commissioner.	Senate only section.	
S.F. No. 2439 – third reading, April 26, 2016.	Identical.	**Sec. 13. Establishment of team.** Amends § 626.558, subd. 1. Adds children's advocacy centers to the list of community-based agencies that may be included on the task force.
S.F. No. 2439 – third reading, April 26, 2016.	Identical.	**Sec. 14. Duties of the team.** Amends § 626.558, subd. 2. Adds a representative of a children's advocacy center to the list of agencies that may assist with case consultation.
S.F. No. 2439 – third reading, April 26, 2016.	Identical.	**Sec. 15. Children's advocacy center; definition.** Adds § 626.558, subd.4. Defines "children's advocacy center."
S.F. No. 2428 – third reading, May 4, 2016. May 5, 2016, referred to House Chief Clerk for comparison.	Similar, except Senate allows task force to create a working group to examine Northstar Care for Children payments. (S.F. No. 2428 and H.F. No. 2683 are substantially similar.)	**Sec. 16. Legislative task force; child protection.** Amends Laws 2015, chapter 71, article 1, section 125. Modifies membership of the legislative task force. Requires the task force to meet at least quarterly and issue an annual report to the legislature and the governor by February 1. Adds additional duties to the duties of the task force. Provides that the task force expires December 31, 2020.

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Article 21: Children and Families		**Article 6: Children and Families**
	House only section.	**Sec. 17. Child care provider liaison and advocate.** Requires the commissioner of human services to create a full-time position to act as a liaison and advocate for child care providers. Provides an immediate effective date.
	House only section.	**Sec. 18. Legislative task force on child care.** Creates a task force to evaluate issues related to affordability and accessibility of child care. Requires the task force to issue a report to the legislature and governor by December 31, 2016. Provides an immediate effective date and a sunset of December 31, 2016.
Section 41 requires that allowable child protection services be expanded to include child care.	Senate only section.	
Section 42 prohibits the Commissioner of Human Services from counting the payment made to families participating in the pilot project related to child development in the first three years of life. This section expires January 1, 2022, and a report is due January 1, 2023.	Substantially similar. Paragraphs (a), (b), and (c) are identical. Paragraphs (d) and (e) have technical differences. Staff recommends the House language.	**Sec. 19. Direction to commissioner; income and asset exclusion.** Prohibits the commissioner of human services from counting payments made to families by a demonstration project as income or assets for purposes of determining eligibility for various human services programs including child care assistance, MFIP, MA, and MinnesotaCare. Defines "income and child development in the first three years of life demonstration project." Provides that this section will only be implemented if Minnesota is chosen as a site for the federal demonstration project, and provides a January 1, 2022, expiration date. Requires the commissioner to report to the legislature on the outcomes of the demonstration project by January 1, 2023.

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Section 43 requires the commissioner to convene a working group to review the impact of removing licensing responsibilities from private agencies, and report back to the legislative committees having jurisdiction over foster care issues by January 15, 2017.	Senate only section.	
Section 44 requires the commissioner to conduct a survey and report on existing liability insurance and the availability of coverage for family child care license holders. The report is due January 16, 2017.	Senate only section.	
	House only section.	**Sec. 20. Revisor's instruction.** Instructs the revisor, in consultation with the commissioner and nonpartisan legislative staff to recodify the Maltreatment of Minors Act. Requires the recodification to be drafted in bill form for introduction in the 2017 session.
	House only section.	**Sec. 21. Repealer; hands off child care.** Repeals Minnesota Statutes, sections 179A.50, 179A.51, 179A.52, and 179A.53 (child care provider unionization).

SENATE		HOUSE
Article 22: Mental Health		**Article 5: Chemical and Mental Health**
Section 1 (245.735, subd. 3) modifies the Excellence in Mental Health Act demonstration project, which establishes certified community behavioral health clinics (CCBHC), by adding components needed to implement the demonstration project, including providers standards, certification process, and prospective payment methodology. This section is effective the day following final enactment.	Paragraphs (a), (c), (d), and (e), have similar language, but technical and minor language differences. Staff recommend Senate. Paragraph (b) has technical differences. Staff recommend House. Paragraph (e) has minor language differences. Staff recommend Senate. Paragraphs (f) to (i) are identical.	**Section 1. Certified community behavioral health clinics.** Amends Minnesota Statutes 2015 Supplement, § 245.735, subd. 3. As part of a federal planning grant for the Excellence in Mental Health demonstration project, this section authorizes the commissioner to develop certification standards for certified behavioral health clinics and establish a prospective payment system for services provided by these clinics. Provides that this section is effective the day following final enactment.
Section 2 (245.735, subd. 4) requires the commissioner to collaborate and partner with stakeholders listed in this section in developing and implementing the CCBHCs. This section is effective the day following final enactment.	Identical.	**Sec. 2. Public participation.** Amends Minnesota Statutes 2015 Supplement, § 245.735, subd. 4. Requires the commissioner to consult, collaborate, and partner with stakeholders in developing and implementing certified community behavioral health clinics. Provides that this section is effective the day following final enactment.
Section 3 (245.99, subd. 2) amends the adult mental illness crisis housing assistance program by changing the eligibility; under current law, persons with serious and persistent mental illness are eligible and the modification allows for persons with serious mental illness to be eligible. This section is effective the day following final enactment.	Senate section is effective the day following final enactment.	**Sec. 3. Rental assistance.** Amends § 245.99, subd. 2. Modifies criteria for the receipt of housing assistance so that persons with a serious mental illness can receive up to 90 days of rental assistance.
Sections 4 and 7 (254B.01, subd. 4a, 254B.05, subd. 5) modify culturally specific programs to include subprograms for purposes of receiving enhanced chemical dependency rates. These sections are effective the day following final enactment.	Senate only sections.	

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Article 22: Mental Health		Article 5: Chemical and Mental Health
Section 5 (254B.03, subd. 4) changes the county share, for fiscal year 2017 only, with regard to chemical dependency services for publically funded clients from 22.95 percent to 15 percent, and changes the county share of the state collection from a private or third-party payment from 22.9 percent to 15 percent.	Technical differences in section formatting. Staff recommend Senate.	**Sec. 4. Division of costs.** Amends § 254B.03, subd. 4. Reduces the county share of cost for chemical dependency treatment to 15 percent for fiscal year 2017 only. The current county share is 22.95 percent. Makes a conforming reduction to the percent reimbursement from the state to the county if the state makes collections from private or third-party payments. Provides that this section is effective July 1, 2016.
Section 6 (254B.04, subd. 2a) adds language stating that it should not be a factor in making placements for chemical dependency treatment whether the treatment facility has been designated an institution for mental disease (IMD).	Identical.	**Sec. 5. Eligibility for treatment in residential settings.** Amends § 254B.04, subd. 2a. Requires that if a person meets the criteria for residential placement, a facility's designation as an institution for mental diseases (IMD) must not be a factor in the placement decision. Provides that this section is effective July 1, 2016.
Section 8 (254B.06, subd. 2) requires the commissioner, for fiscal year 2017 only, to allocate 85 percent, instead of 77.05 percent, of the patient and third-party payments to the special revenue account, and allocate 22.95 percent, instead of 15 percent, to the county of financially responsible for the patient.	Both House and Senate achieve same purpose, technical drafting differences. Staff recommend House.	**Sec. 6. Allocation of collections.** Amends § 254B.06, subd. 2. Changes the allocation of collections for fiscal year 2017 only. To conform to the change in county share of cost in subdivision 1, the amendment to this subdivision requires the commissioner to allocate 15 percent of the collection to the county of financial responsibility. Provides that this section is effective July 1, 2016.
Section 9 (254B.06, subd. 4) adds a new subdivision prohibiting the commissioner from denying reimbursement to a program designated as an IMD due to a reduction in federal financial participation and the addition of new residential beds.	Identical.	**Sec. 7. Reimbursement for institutions for mental disease.** Amends § 254B.06, by adding subdivision 4. Prohibits the commissioner from denying reimbursement to a program designated as an IMD due to a reduction in federal financial participation and the addition of new residential beds. Provides that this section is effective July 1, 2016.

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	House only section.	**Sec. 8. Pilot projects; treatment for pregnant and postpartum women with substance use disorder.** Adds § 254B.15. Directs the commissioner of human services to establish pilot projects, within the limits of federal funds available specifically for this purpose, to provide substance use disorder treatment and services to pregnant and postpartum women. Requires the commissioner to apply for any available federal grant funds for the pilot projects.
Section 10 (256B.0621, subd. 10) allows medical assistance reimbursement for interactive video for relocation case management services, which helps recipients gain access to needed services and supports if they choose to move from an institution to the community.	Identical.	**Sec. 9. Payment rates.** Amends § 256B.0621, subd. 10. Adds that in assisting a client who is moving from an institution to the community, a case manager may bill medical assistance for relocation targeted case management services conducted by interactive video as provided in section 256B.0924, subd. 4a.
Section 11 (256B.0622, subd. 12) allows the commissioner to use grant funds, within available appropriations, for assertive community treatment teams, intensive residential treatment services, or crisis residential services. This section is effective the day following final enactment.	Senate only section.	
Section 12 (256B.0625, subd. 20) modifies the mental health case management section of law to allow medical assistance reimbursement for contact by interactive video, that meet the requirements of section 256B.0625, subdivision 20b.	Identical except paragraph (p). House states "services must actively support" and Senate states "services are expected to actively support." Minor language differences. Staff recommend House.	**Sec. 10. Mental health case management.** Amends § 256B.0625, subd. 20. Provides that medical assistance and MinnesotaCare will pay for mental health case management services provided by interactive video if the interactive video contact meets the requirements of subdivision 20b.

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Article 22: Mental Health		Article 5: Chemical and Mental Health
Section 13 (256B.0625, subd. 20b) adds a new subdivision creating a new benefit under the medical assistance chapter for mental health targeted case management through interactive video.	Identical except for technical formatting and punctuation differences, and House includes a cross-reference to MA payment. Staff recommend House, except delete cross-reference in House paragraph (a).	**Sec. 11. Mental health targeted case management through interactive video.** Amends § 256B.0625, by adding subd. 20b. Provides, subject to federal approval, that medical assistance will pay for mental health targeted case management services provided by interactive video to a person who resides in a hospital, nursing facility, or residential setting staffed 24 hours a day, seven days a week. Use of interactive video must be approved in the case plan, must be in the best interests of the person, and must be approved by the person receiving services, the case manager, and the provider operating the setting where the person resides.
Section 14 (256B.0924, subd. 4a) allows medical assistance reimbursement for interactive video contact for targeted case management for vulnerable adults and adults with developmental disabilities. This section also sets the parameters for contact by interactive video for targeted case management. Interactive video is subject to federal approval, and is allowed if the requirements are met.	Identical except some grammar, punctuation, and stylistic differences. Staff recommend House.	**Sec. 12. Targeted case management through interactive video.** Amends § 256B.0924, by adding subd. 4a. Paragraph (a) provides, subject to federal approval, that medical assistance will pay for targeted case management services provided by interactive video to a person who resides in a hospital, nursing facility, or residential setting staffed 24 hours a day, seven days a week. Use of interactive video must be approved in the case plan, must be in the best interests of the person, and must be approved by the person receiving services, the case manager, and the provider operating the setting where the person resides. Provides that interactive video cannot be used for more than 50 percent of the minimum required face-to-face contacts.

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Article 22: Mental Health		Article 5: Chemical and Mental Health
Section 15 establishes a rural demonstration project to assist transition-aged youth and young adults with emotional behavioral disturbance or mental illness in making a successful transition into adulthood. Requires a report by January 1, 2019, on the status and outcomes of the demonstration project.	Both Senate and House create a grant program for a rural demonstration project, and language is substantially similar except for paragraph (a). Senate requires commissioner to grant funds to a children's mental health collaborative, and House states that children's mental health collaboratives are eligible to apply for grant funding, and the commissioner must solicit proposals. Some differences in paragraph (c) as to who the commissioner shall report, and also data must be collected and reported "as outlined" (Senate) or "per guidelines approved" (House) by commissioner.	**Sec. 14. Rural demonstration project.** Creates a grant program for a children's mental health collaborative to provide individualized coaching to rural youth ages 15 to 25 currently in the mental health system or with emerging mental health conditions so that these youth are able to achieve their personal goals in education, employment, housing, and community functioning. Requires the grantee to use all available sources of funding and to complete a program evaluation. Instructs the commissioner to issue a report to legislative committees with jurisdiction over mental health on the status and outcome of the demonstration by January 15, 2019. Requires the collaborative to report outcome data to the commissioner.
Section 16 requires the Commissioner of Human Services to seek federal approval for interactive video contact.	Technical differences. Staff recommend House.	**Sec. 13. Commissioner duty to seek federal approval.** Instructs the commissioner to seek federal approval to implement case management via interactive video.

Article 23: Direct Care and Treatment	Senate Only	
Section 1 (**245.4889, subd. 1)** allows the commissioner to use children's mental health grants for sustaining extended-stay inpatient psychiatric hospital services for children and adolescents.	Senate only	

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Article 23: Direct Care and Treatment	Senate Only	
Section 2 (246.50, subd. 7) clarifies the definition related to the county of financial responsibility for state-operated services.	Senate only	
Section 3 (246.54) increases the county liability for the cost of care for direct care and treatment services. Under new **subdivision 1b** for care at state-operated community-based behavioral health hospitals (CBHH), the county payment for the cost of care is 100 percent when the facility determines that it is clinically appropriate to discharge the client. Under new **subdivision 1c**, language is moved from existing law related to the county liability for the Minnesota Security Hospital, (MSH) forensic nursing home, and forensic transition programs. The new county liability for the cost of care at the residential competency restoration program is 20 percent for each day the client spends in the program while the client is in need of services; 50 percent for each day the client spends in the program, but the client no longer needs restoration services; and 100 percent for each day the client spends in the program once the charges against the client have been resolved or dropped.	Senate only	
Section 4 (246B.01, subd. 1b) clarifies the definition related to the county of financial responsibility for the Minnesota Sex Offender Program.	Senate only	
Section 5 (**246B.01, subd. 2b)** expands the definition of “cost of care” for the Minnesota Sex Offender Program (MSOP), to include aftercare services and supervision.	Senate only	

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Article 23: Direct Care and Treatment	Senate Only	
Section 6 (**246B.035)** requires the annual MSOP performance report by February 15 beginning in 2017.	Senate only	
Section 7 (**246B.10)** amends the liability of the county to pay for the cost of care provided by the Minnesota Sex Offender Program to include services in a facility or services while on provisional discharge.	Senate only	
Section 8 requires a quarterly report on the Anoka Metro Regional Treatment Center, MSH, and CBHH containing information on the number of licensed beds, budgeted capacity, occupancy rate, number of OSHA recordable injuries and the number of those injuries that are due to patient aggression or restraint, clinical and direct care positions funded, and the percentage of those positions that are filled.	Senate only	

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Article 24: Continuing Care		Article 1: Continuing Care
	House only section Identical to SF 2325 – Recommended to pass and referred to the floor on 5/4/2016	**Art. 1, § 2. Exceptions for replacement beds after June 30, 2003.** Amends § 144A.071, subd. 4c. Moves payment rate adjustments for certain exception projects approved by the commissioner of health from the property rate to the external fixed costs rate. Modifies a project in Goodhue County to consolidate two nursing facilities into one newly renovated 64-bed facility resulting in the delicensure of 85 beds (the current language results in the delicensure of 69 beds). Modifies the calculation of the rate adjustment for the project in Goodhue County. Makes this section effective for rate years beginning on or after January 1, 2017, except that the transfer of the rate adjustment for the Goodhue County project from the property rate to the external fixed costs rate is effective for rate years beginning on or after January 1, 2017, or upon completion of the closure and new construction, whichever is later.
	House only section Identical to SF 2325 – Recommended to pass and referred to the floor on 5/4/2016	**Art. 1, § 3. Consolidation of nursing facilities.** Amends § 144A.071, subd. 4d. Modifies rate adjustments for consolidation of nursing facilities by moving the adjustment from the property rate to the external fixed costs rate. Makes this section effective for rate years beginning on or after January 1, 2017.
	House only section	**Art. 1, § 4. Moratorium exception funding.** Amends § 144A.073, subd. 13. Clarifies that the commissioner of health may approve moratorium exception projects, in fiscal year 2013, for which the full annualized state share of MA costs does not exceed $1,000,000 plus any carryover of previous appropriations for this purpose.

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Article 24: Continuing Care		Article 1: Continuing Care
	House only section	**Art. 1, § 5. Moratorium exception funding.** Amends § 144A.073, subd. 14. Clarifies that the commissioner of health may approve moratorium exception projects, in fiscal year 2015, for which the full annualized state share of MA costs does not exceed $1,000,000 plus any carryover of previous appropriations for this purpose.
	House only section	**Art. 1, § 6. Moratorium exception funding.** Amends § 144A.073, by adding subd. 15. In fiscal year 2017, allows the commissioner of health to approve moratorium exception projects for which the full annualized state share of MA costs does not exceed $1,000,000 plus any carryover of previous appropriations for this purpose.
	House only section	**Art. 1, § 7. Nursing homes and certified boarding care homes.** Amends § 144A.611, subd. 1. Modifies reimbursable expenses payable to nursing assistants by: (1) adding textbooks to the list of reimbursable expenses; and (2) allowing adult training programs to be reimbursed. Updates a cross-reference.
	House only section	**Art. 1, § 8. Reimbursement for training program and competency evaluation costs.** Amends § 144A.611, subd. 2. Makes a conforming change.
	House only section	**Art. 1, § 9. Reimbursement for adult basic education components.** Amends § 144A.611, by adding subd. 4. Paragraph (a) requires nursing homes and certified boarding care homes to provide reimbursement for costs related to additional adult basic education components of an approved nursing assistant training program.

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Article 24: Continuing Care		Article 1: Continuing Care
		Paragraph (b) lists the adult basic education components eligible for reimbursement and limits reimbursement of those components to 30 percent of the cost of tuition, textbooks, and competency evaluation. Paragraph (c) prohibits an adult training program from billing program students, nursing facilities, or certified boarding care homes until the program student has been employed by the nursing facility as a certified nursing assistant for at least 90 days. **Effective date.** Makes this section effective for costs incurred on or after October 1, 2016.
Section 1 (245A.10, subd. 4) paragraph (b), clause (5) extends by another year the grandfathered licensing fee structure for providers previously licensed under chapter 245B. **Paragraph (m)** modifies the licensing fees for providers of those home and community based services that require licensure under 245D. The new annual fee is the higher of $450 or 0.27 percent of the provider's revenue derived from the section of 245D licensed services. The commissioner must calculate a provider's fee based on paid claims invoiced by that provider. **Paragraph (m**) is effective for fees paid after July 1, 2017.	Senate only section	

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Section 2 (245A.10, subd. 8) moves revenue collected from DHS licensing activities from the state government special revenue fund to a special revenue fund. The sources of the revenue include various application fees, as well as various licensing fees, including those from childcare center, chemical dependency treatment programs, residential facilities, foster care providers, adoption services providers, adult day care centers, 245D licensed services, and certain mental health centers and clinics. This section is effective July 1, 2017.	Senate only section	
Section 3 (245D.03, subd. 1) requires providers of individual community living support to be licensed under the home and community based services standards under 245D. This section is effective July 1, 2017.	Senate only section	
Section 4 (256B.0949) adds new language concerning an existing benefit for the treatment of children with autism spectrum disorders and related conditions.	Senate only section	
Subd. 1 changes the name of the existing autism early intensive intervention benefit to the Early Intensive Developmental and Behavioral Intervention (EIDBI) benefit and includes language specifying that the benefit is also available for the treatment of conditions related to autism spectrum disorders (ASD).		

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Article 24: Continuing Care		Article 1: Continuing Care
Subd. 2 includes several new definitions, including definitions of “agency,” “ASD and related conditions,” “clinical supervision,” “comprehensive multidisciplinary evaluation,” “individual treatment plan,” “legal representative,” “person-centered,” and definitions by cross-reference for various EIDBI professionals and providers.		
Subd. 3 modifies the eligibility criteria for the EIDBI benefit to allow children with diagnoses of a condition related to an autism spectrum disorder to be eligible.		
Subd. 3a requires providers to ensure that children and their families receive EIBDI services in a culturally and linguistically appropriate manner.		
Subd. 4 specifies the conditions a diagnosis of ASD or a related condition must meet in order for a child to be eligible for the benefit; and specifies additional information that may be included in a diagnostic assessment.		
Subd. 5 requires a comprehensive multidisciplinary evaluation (CMDE) of potential service recipients be completed to determine if EIDBI services are medically necessary; and specifies what must be included in the evaluation.		
Subd. 5a specifies the CMDE provider qualification requirements.		

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Subd. 6 requires an EIDBI professional to develop and monitor a child's individual treatment plan and specifies the required elements of an individual treatment plan.		
Subd. 6a specifies that EIDBI services may not replace services provided in a school or other settings and must be coordinated with services defined in a child's individualized education plan or individualized family service plan; requires the commissioner to integrate medical authorization procedures for this benefit with authorization procedures for other services.		
Subd. 7 requires that a child's progress toward achieving treatment goals be evaluated at least every six month and specifies who must supervise the evaluation and the required elements of the evaluation.		
Subd. 8 requires the commissioner to work with stakeholders to continue to refine the details of the EIBDI benefit and incorporates new language and terminology into the list of suggested issues the commissioner could consider.		
Subd. 9 specifies the requirements any treatment method must meet to be a recognized treatment option for the purposes of the EIDBI benefit.		
Subd. 10 is existing language.		

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Subd. 11 is existing language. **Subd. 12** is existing language.		
Subd. 13 lists and describes the services covered by the EIDBI benefit.		
Subd. 14 lists the rights of children and of their families who receive the EIDBI benefit.		
Subd. 15 specifies the provider qualification requirements for each of the following EIBDI providers: level I treatment providers; level II treatment providers; level III treatment providers; and qualified supervising professionals.		
Subd. 16 lists and describes the duties and responsibilities of an agency.		
Subd. 17 lists and describes the agency qualification requirements, as well as additional duties and responsibilities of agencies		
Subd. 18 requires the commissioner to consult with stakeholders to determine if there exists a shortage of qualified providers of EIDBI services, and if so, to develop a process and criteria for granting exceptions to the provider qualification requirements, the medical assistance provider enrollment requirements, or other applicable requirements. The commissioner is required to provide annual updates to the legislature concerning the status of the shortage of qualified EIBDI providers		

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and the use of the qualification exception process. The commissioner may not terminate the exemption authority without providing 30 days' notice for public comment.		
	House only section	**Art. 1, § 15. Employee scholarship costs and training in English as a second language.** Amends § 256B.431, subd. 36. Updates a cross-reference to conform to the changes made to section 144A.611 (reimbursable expenses payable to nursing assistants).
	House only section Identical to SF 2325 – Recommended to pass and referred to the floor on 5/4/2016	**Art. 1, § 16. External fixed costs.** Amends § 256B.441, subd. 13. Adds consolidation rate adjustments to the definition of "external fixed costs."
Section 5 (256B.442, subd. 30) corrects a drafting error in the nursing facility payment rate reform that passed in 2015. The total care-related per diem is defined elsewhere in the payment rate language as the sum of the direct care costs per diem and the other care-related per diem. The median total care-related per diem was inadvertently defined as including only the direct care component of the total care-related per diem.	Senate only section (S.F. 2430 passed off the Senate floor on 5/3/2016.) Technical amendment needed – effective date.	
	House only section Identical to SF 2325 – Recommended to pass and referred to the floor on 5/4/2016	**Art. 1, § 17. Calculation of payment rate for external fixed costs.** Amends § 256B.441, subd. 53. Adds consolidation rate adjustments to the calculation of the external fixed costs payment rate.
Section 6 (256B.441, subd. 66) adds nonprofit nursing homes in Moorhead to an already existing rate increase that applies to	Technical difference. (Staff recommends Senate.)	**Art. 1, § 18. Nursing facilities in border cities.** Amends § 256B.441, subd. 66. Modifies the section governing nursing facility operating rates in border cities. Under current law, the commissioner must increase operating payment rates for

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nonprofit nursing homes in Breckenridge. The Moorhead rate increase would be effective January 1, 2020.		nonprofit nursing facilities in Breckenridge to be equal to the rates for a nonprofit nursing facility in an adjacent city in another state and in cities contiguous to the adjacent city. Expands this section to nonprofit facilities located in Moorhead, effective for the rate year beginning January 1, 2020. Specifies that the commissioner must compare the rates in Minnesota border cities with other cities on October 1 each year, with the rate adjustments to be effective on January 1 of the following year. Existing language stipulates that rate adjustments under this border city subdivision are not subject to the limits in 256B.441, subdivision 50 and subdivision 51. Clarifies that the rate adjustments under the border cities subdivision are not subject to the total care-related limit in subdivision 50 and are not limited to the other operating price in subdivision 51.
Section 7 (256B.4912, subd. 11) requires home and community based service providers to submit, and the commissioner of human services to analyze, wage and staffing data for certain HCBS services.	Senate only section	
Section 8 (256B.4913, subd. 4a) modifies the historical rate for day services by setting the rate equal to the weighted average historical rate for each provider in the county, rather than the historical rate of the provider.	Senate only section	

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Section 9 (256B.4914, subd. 5) Paragraph (i) requires the commissioner to make recommendations by January 15, 2017, for incorporating into the disability waiver rate system framework the cost of increased licensing fees under section 245A.10, subdivision 4, paragraph (m).	Senate only section	
Section 10 (256B.4914, subd. 10) replaces “county” and “county and tribal” with “lead agency.”	Senate only section	
Section 11 (256B.4914, subd. 11) replaces “county” with “lead agency.”	Senate only section	
Section 12 (256B.4914, subd. 14) clarifies the circumstances under which an application for an exception to the rates set under the disability waiver rate setting system are allowed by permitting applications when an individual’s services needs cannot be met through the weighted county average historical rate.	Senate only section	
Section 13 (256B.4914, subd. 15) replaces “county and tribal” and “county” with “lead agency.”	Senate only section	
Section 14 (Provider Rate Grant Increases Effective July 1, 2016) Paragraph (a) requires the commissioner of human services to increase by 2.72 percent the rate for certain home and community based services that are now subject to the U.S. Department of Labor’s Home Care Rule, which requires most home care workers to be paid for overtime and travel time.	Senate only section	

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Paragraph (b) specifies the services to which the rate increase applies.		
Paragraph (c) requires managed-care plans and county-based purchasing plans to pass through the increase in capitation rates to the providers of the eligible services.		
Paragraph (d) requires lead agencies to increase each consumer-directed community supports recipient's budget by 2.27 percent.		
Paragraph (e) requires the commissioner to include the increase in the rates under the disability waiver rate setting system.		
Paragraph (f) requires that providers use 90 percent of the additional revenue to increase compensation-related costs for employees other than central office employees or persons paid by the provider under a management contract.		
Paragraph (g) defines "compensation-related costs."		
Paragraph (h) gives providers discretion to distribute the additional revenue across the eligible compensation-related costs.		

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Paragraph (i) requires providers to obtain from an exclusive bargaining representative a letter of acceptance of a plan for distribution of 90 percent of the rate increase to members of the bargaining unit.		
Paragraph (j) requires providers to develop and submit to the commissioner a plan for the distribution of 90 percent of the rate increase. The distribution plan must include the provider's overtime policy, and the overtime policy must not limit overtime when a service recipient's needs would go unmet without a worker exceeding 40 hours in a week.		
Paragraph (k) requires providers to post notice of its distribution plan in a manner accessible to employees and provide instructions for employees to contact the commissioner if they believe they have not received the compensation increases.		
Section 15 (Instruction to the Commissioner) requires the commissioner of human services to update the medical assistance state plan to be consistent with the statutory changes to the EIDBI benefit under section 256B.0494.	Senate only section	
	House only section	**Art. 1, § 19. Employment services pilot project; Dakota County.** Paragraph (a) directs the commissioner of human services to request, by October 1, 2016, necessary federal authority from CMS to implement a community-based employment services pilot project in Dakota County for people who are receiving services through HCBS waivers

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		using a rate methodology consistent with the principles of the Disability Waiver Rate System. Paragraph (b) lists responsibilities of Dakota County under the pilot project. Paragraph (c) lists the services that must be provided under the pilot project. Paragraph (d) requires the commissioner to consult with Dakota County on this pilot project and to report the results of the project to the legislature by January 15, 2019. **Effective date.** Makes this section effective July 1, 2016, or upon federal approval, whichever is later, and makes this section expire January 15, 2019.
Section 16 (Revisor's Instruction) codifies the home and community-based incentive pool, which provides incentive payments to providers for innovations that achieve integrated competitive employment and living in integrated settings.	Senate only section	
	House only section	**Art. 1, § 20. Revisor's instruction.** Instructs the revisor of statutes to change cross-references in Minnesota Rules, chapter 2960, 9503, and 9525, resulting from the repealer adopted in the new Positive Support Strategies rule. Allows the revisor to make technical and other necessary changes to preserve the meaning of the text. **Effective date.** Provides an immediate effective date.

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Article 25: Health Care		**Articles 1, 2, and 3**
Section 1 (16A.724, subd. 2) increases the amount transferred each biennium from the health care access fund to the general fund to reflect the current value of the medical assistance and MinnesotaCare revenue that is included in the HMO premiums and provider gross revenue taxes to cover the increase in the provider's rates.	Senate only	
	House only	**A3, § 1. Legislative enactment required.** Adds § 45.0131. **Subd. 1. Agency agreements.** Prohibits the commissioner of commerce from entering into or renewing any interagency agreement or service level agreement, or related agreement, with a value of more than $100,000 a year, with any state department, state agency, or the Office of MN.IT Services, unless this is authorized by enactment of a new law. Provides that agreements without a specific expiration date expire two years from the effective date of this section or of the agreement, unless authorized by enactment of a new law. **Subd. 2. Transfers.** Prohibits the commissioner from transferring appropriations and funds in amounts over $100,000 across agency accounts or programs, unless this is authorized by enactment of a new law. **Subd. 3. Definitions.** Defines "state department" and "state agency." **Effective date.** Provides an immediate effective date.
Section 2 (62J.497, subd. 1) adds a definition of utilization review organization.	Senate only	

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Section 3 (62J.497, subd. 3) requires group purchasers and utilization review organizations other than workers' compensation plans and the medical component of an automobile insurance coverage, to develop processes to ensure that prescribers can obtain information about covered drugs from the same class or classes or a drug originally prescribed that was denied.	Senate only	
Section 4 (62M.02, subd. 10a) adds a definition for “drug.”	Senate only	
Section 5 (62M.02, subd. 11a) adds a definition for “formulary.”	Senate only	
Section 6 (62M.02, subd. 12) modifies the definition of health benefit plan to include a health plan that provides coverage of prescription drugs.	Senate only	
Section 7 (62M.02, subd. 14) modifies the definition of “outpatient services” to include prescription drugs.	Senate only	
Section 8 (62M.02, subd. 14a) adds a definition for “prescription.”	Senate only	
Section 9 (62M.02, subd. 14b) adds a definition for “prescription drug order.”	Senate only	
Section 10 (62M.02, subd. 15) modifies the definition of “prior authorization” to include preadmission review, pretreatment review, quantity limits, step therapy, utilization, and case management and any utilization review organization’s requirement that an enrollee or provider notify the utilization review organization prior to providing a service.	Senate only	

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Section 11 (62M.02, subd. 17) modifies the definition of "provider" to include a licensed pharmacist.	Senate only	
Section 12 (62M.02, subd. 18a) adds a definition for "quantity limit."	Senate only	
Section 13 (62M.02, subd. 19a) adds a definition for "step therapy."	Senate only	
Section 14 (62M.05, subd. 3a) modifies the time in which an initial determination on requests for utilization review on prescription drug requests must be communicated to the provider and enrollee from ten business days to five business days of the request.	Senate only	
Section 15 (62M.05, subd. 3b) modifies the time in which notification of an expedited initial determination to either certify on prescription drug requests or not to certify must be provided to the provider and enrollee from no later than 72 hours to no later than 36 hours from the initial request.	Senate only	
Section 16 (62M.06, subd. 2) modifies the time in which a utilization review organization must notify the enrollee and attending health care professional of its determination on the expedited appeal on prescription drug requests from no later than 72 hours to no later than 36 hours after receiving the expedited appeal.	Senate only	

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Section 17 (62M.06, subd. 3) modifies the time in which a utilization review organization must notify the enrollee, attending health care professional, and claims administrator of its determination on a standard appeal on prescription drugs from 30 days to 15 days upon receipt of the notice to appeal. If the utilization review organization cannot make a determination within 15 days due to circumstances outside the control of the review organization, the review organization may take up to ten additional days to notify the enrollee, attending health care professional, and claims administrator of its determination. If it takes any additional days beyond the initial 15-day period to make its determination, it must inform the enrollee, attending health care professional, and claims administrator in advance of the extension and reasons for it.	Senate only	
Section 18 (62M.07), Paragraph (d), specifies that any authorization for a prescription drug must remain valid for the duration of an enrollee's contract term so long as the drug continues to be prescribed to the patient, the drug remains safe, has not been withdrawn from use by the FDA or the manufacturer, and no drug warnings or recommended changes in drug usage has occurred. **Paragraph (e)** prohibits a utilization review organization, health plan company, or claims administrator from imposing step therapy requirements for enrollees currently on a prescription drug for six specified classes. **Paragraph (f)** prohibits a utilization review organization, health plan company, or claims	Senate only	

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administrator from imposing step therapy requirements on enrollees who are currently taking a prescription drug for which the patient satisfied a previous step therapy requirement.		
Section 19 (62M.09, subd. 3) requires all physicians conducting the review in connection with any policy issued by a health plan company, regardless of size, be licensed in Minnesota.	Senate only	
Section 20 (62M.11) permits a provider to file a complaint regarding compliance with the requirements of this chapter or regarding a determination not to certify directly to the commissioner responsible for regulating the utilization review organization.	Senate only	
Section 21 (62Q.81, subd. 4) clarifies that autism spectrum disorder treatments specified in section 62A.3094 are rehabilitative and habilitative services for purposes of the essential health benefits. This section is effective upon a formal determination from CMS that these services are not a new state mandate.	Senate only	
Section 22 (62Q.83) creates prescription drug benefit transparency and management requirements. **Subdivision 1** defines the following terms: drug; enrollee contract year; formulary; health plan company; and prescription. **Subdivision 2** requires a health plan company that cover prescription drugs and uses a formulary to make its formulary and related benefit information available by	Senate only	

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Article 25: Health Care		Articles 1, 2, and 3
electronic means and, upon request, in writing at least 30 days prior to annual renewal dates. **Subdivision 3, paragraph (a),** specifies that once a formulary has been established a health plan company, may at any time during an enrollee's contract year, expand its formulary by adding drugs to the formulary; reduce the copayments or coinsurance; or move a drug to a benefit category that reduces the enrollee's cost. **Paragraph (b)** states that a health plan company may remove a brand name drug from its formulary or place a brand name drug in a benefit category that increases an enrollee's cost only if an A-rated generic or multisource brand name equivalent is added to the formulary at a lower cost to the enrollee and upon 60 notice to prescribers, pharmacists, and affected enrollees. **Paragraph (c)** permits a health plan company to change utilization review requirements or move drugs to a benefit category that increases an enrollee's cost during the enrollee's contract year upon a 60-day notice provided the change does not apply to enrollees who are currently taking the drugs affects by the change for the duration of the enrollee's contract year. **Paragraph (d)** permits a health plan company to remove any drug from its formulary that has been deemed unsafe by the FDA or it has been withdrawn by the FDA or the manufacturer, or an independent source has issued drug specific warnings or recommended changes in drug usage.		

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Subdivision 4, paragraph (a) requires a health plan company to establish and maintain a transition process to prevent gaps in prescription drug coverage for enrollees with ongoing prescription drug needs who are affected by changes in formulary drug availability. **Paragraph (b)** requires the process to provide coverage for at least 60 days. **Paragraph (c)** requires that any cost-sharing applied be based on the defined prescription drug benefit terms and must be consistent with any cost-sharing that would be charged for nonformulary drugs approved under a medication exceptions process. **Paragraph (d)** requires the health plan company to ensure that written notice is provided to each affected enrollee and prescriber within three business days after adjudication of the transition coverage. **Subdivision 5, paragraph (a)** requires each health plan company to establish and maintain a medication exceptions process that allows enrollees, providers, and an authorized representative to request and obtain coverage approval in certain situations. **Paragraph (b)** requires the exception request to remain valid for the duration of an enrollee's contract term provided that the medication continues to be prescribed of the same condition, and the medication has not been withdrawn by the manufacturer or the FDA.		

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Paragraph (c) requires the medical exceptions process to comply with the requirements under chapter 62M (utilization review).		
	House only	**A3, § 2. Application of other law.** Amends § 62V.03, subd. 2. Requires meetings of the Minnesota Eligibility System Executive Steering Committee to comply with the open meeting law.
	House only	**A3, § 3. Appointment.** Amends § 62V.04, subd. 2. Removes the commissioner of human services or a designee from membership on the MNsure board and adds a member representing the interests of the general public.
	House only	**A3, § 4. Terms.** Amends § 62V.04, subd. 3. Removes a reference to the term served on the MNsure board by the commissioner of human services or a designee, to conform to section 62V.04, subdivision 2.
	House only	**A3, § 5. Conflicts of interest.** Amends § 62V.04, subd. 4. Modifies a cross-reference to require all board members, including the member representing the interests of the general public, to comply with the conflict of interest requirements for MNsure board members. (Under current law the conflict of interest requirements do not apply to the commissioner of human services.)
Section 23 (62V.041) establishes a shared eligibility system that supports the eligibility determinations that use a modified adjusted gross income methodology for medical assistance, MinnesotaCare, and qualified health plan enrollment. Requires the steering committee of the shared	Numerous differences: • Senate 7 members (2 appointed by the commissioner of human services, 2 by MNsure, 2 by MN.IT, and 1 county representative appointed by the commissioner) and House 4 members (1	**A3, § 10. Minnesota Eligibility System Executive Steering Committee.** Adds § 62V.056. Establishes an executive steering committee to govern the Minnesota eligibility system.

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eligibility system to establish an overall governance structure for the system, including setting goals and priorities, allocating resources, and making major system decisions. Requires the steering committee to operate under a consensus model and give particular attention to parts of the system with the largest enrollments and the greatest risks. Requires MN.IT to be responsible for the design, building, maintenance, operation, and upgrade of the information technology for the system.	appointed by the commissioner, 1 by MNsure, 1 by county associations, and 1 nonvoting member by MN.IT) • Senate requires the commissioner of human services to designate as chair one of the members appointed by the commissioner; House designates the member appointed by MN.IT as chair • House requires steering committee costs to be paid for by DHS, MN.IT, and MNsure • House requires tracking of funding and expenditures and quarterly reports to LOC • Senate has language on operating by consensus, to extent feasible • House specifies criteria for meetings and voting • House has reference to MN.IT operating under chapter 16E • Senate has immediate effective date • Also technical differences (House Article 3, sections 2 and 11 are related provisions)	**Subd. 1. Definition; Minnesota eligibility system.** Defines Minnesota eligibility system as the system that supports eligibility determinations using the modified adjusted gross income (MAGI) methodology for certain medical assistance applicants and enrollees (mainly children, parents, pregnant women, and adults without children); for MinnesotaCare applicants and enrollees; and for people applying for or enrolled in a qualified health plan. **Subd. 2. Establishment; committee membership.** Establishes the Minnesota Eligibility System Executive Steering Committee and specifies committee membership: one member appointed by the commissioner of human services, one member appointed by the MNsure board, one member representing counties, and one nonvoting member representing MN.IT. Requires steering committee costs to be paid from the budgets of the Department of Human Services, MN.IT, and MNsure. **Subd. 3. Duties.** Directs the steering committee to establish a governance structure for the Minnesota eligibility system and to be responsible for the system's governance. Requires quarterly reports to the Legislative Oversight Committee, and requires the steering committee to adopt bylaws, policies, and agreements to administer the Minnesota eligibility system.

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		Subd. 4. Meetings. Requires steering committee meetings to be held in the State Office Building and to be available for viewing through the legislature's Web site. Requires the steering committee to provide opportunities for public testimony at every meeting and to post meeting documents to the legislature's Web site. Requires steering committee votes to be recorded, with each member's vote identified. **Subd. 5. Administrative structure.** Lists duties of the Office of MN.IT Services for the Minnesota eligibility system.
Section 24 (62V.05, subd. 2) requires MNsure to retain or collect up to 1.5 percent of total premiums for individual health plans and dental plans sold to Minnesota residents through MNsure and outside of MNsure to fund the operations of MNsure beginning January 1, 2018. (Currently MNsure retains up to 3.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure).	Senate sets premium assessment at 1.5 percent of premiums for policies both inside and outside the exchange, effective 1-1-18, and excludes small group plans from this calculation. House reduces assessment to 1.75 percent of premiums for policies sold through the exchange, effective 1-1-17, and continues to include small group plans in this calculation. Effective 1-1-18, House sets assessment at 1.75 percent if specified performance criteria are met, with a reduction to 1.5 percent if the criteria are not met. House sets limit of 60 percent of the MCHA assessment for CY 2012; Senate retains the current law limit of 100 percent. House also strikes outdated language related to the assessment phase-up.	**A3, § 6. Operations funding.** Amends § 62V.05, subd. 2. Strikes paragraphs that established MNsure funding and authorized cash flow assistance in prior calendar years. Establishes the following funding structure for MNsure for current and future calendar years. Paragraph (a): For calendar year 2016 only, allows MNsure to retain up to 3.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure. Paragraph (b): For calendar year 2017, allows MNsure to retain up to 1.75 percent of total premiums for plans sold through MNsure. Paragraph (c): For calendar year 2018 and subsequent calendar years, allows MNsure to retain up to 1.75 percent of total premiums for plans sold through MNsure, if an

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		independent third party certifies that MNsure satisfied the listed benchmarks in the previous calendar year. Paragraph (d): For calendar year 2018 and subsequent calendar years, if an independent third party does not certify that MNsure met the benchmarks in paragraph (c), allows MNsure to retain up to 1.5 percent of total premiums for plans sold through MNsure. Paragraph (f): Lowers the ceiling for the total amount MNsure may retain to fund its operations, from 100 percent to 60 percent of funds collected in MCHA member assessments in calendar year 2012. **Effective date.** Makes this section effective July 1, 2016.
	House only	**A3, § 8. Legislative enactment required.** Amends § 62V.05, by adding subd. 12. (a) Prohibits the MNsure board from entering into or renewing any interagency agreement or service level agreement, or related agreements, with a value of more than $100,000 a year, with any state department, state agency, or the Office of MN.IT Services, unless this is authorized by enactment of a new law. Provides that agreements without a specific expiration date expire two years from the effective date of this section or of the agreement, unless authorized by enactment of a new law. (b) Prohibits the board from transferring appropriations and funds in amounts over $100,000 across agency accounts or programs, unless this is authorized by enactment of a new law. (c) Defines “state department” and “state agency.”

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		Effective date. Provides an immediate effective date.
	House only	**A3, § 9. Limitation on appropriations and transfers.** Amends § 62V.05 by adding subd. 13. Prohibits money from any state fund or account from being appropriated or made available to MNsure, or transferred or provided to MNsure by any state agency or entity of state government, unless the appropriation, transfer, or transaction is specifically authorized through enactment of a new law.
	House only	**A1, § 1. Additional notice to applicants.** Adds § 62V.055. Requires the MNsure board, in consultation with the commissioner of human services, to include in the combined application for MA, MinnesotaCare, and qualified health plan coverage available through the MNsure portal, information and notice on: (1) the order in which eligibility for health care programs will be determined; (2) that persons eligible for MA are not eligible for MinnesotaCare, and that persons eligible for MA or MinnesotaCare are not eligible for advanced premium tax credits and cost-sharing subsidies; and (3) that the state may claim repayment from the estates of MA enrollees, for the cost of medical care or premiums paid for that care.
	House only Technical amendment needed: cross-reference should read 62V.056.	**A3, § 11. Review of Minnesota eligibility system funding and expenditures.** Amends § 62V.11, by adding subd. 5. Requires the Legislative Oversight Committee to review quarterly reports submitted by the steering committee related to Minnesota eligibility system funding and expenditures.

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	House only	**A3, § 12. Legislative enactment required.** Amends § 144.05, by adding subd. 6. (a) Prohibits the commissioner of health from entering into or renewing any interagency agreement or service level agreement, or related agreements, with a value of more than $100,000 a year, with any state department, state agency, or the Office of MN.IT Services, unless this is authorized by enactment of a new law. Provides that agreements without a specific expiration date expire two years from the effective date of this section or of the agreement, unless authorized by enactment of a new law. (b) Prohibits the commissioner from transferring appropriations and funds in amounts over $100,000 across agency accounts or programs, unless this is authorized by enactment of a new law. (c) Defines "state department" and "state agency." **Effective date.** Provides an immediate effective date.
	House only	**A3, § 13. Legislative enactment required.** Amends § 256.01, by adding subd. 41. (a) Prohibits the commissioner of human services from entering into or renewing any interagency agreement or service level agreement, or related agreements, with a value of more than $100,000 a year, with any state department, state agency, or the Office of MN.IT Services, unless this is authorized by enactment of a new law. Provides that agreements without a specific expiration date expire two years from the effective date of this section or of the agreement, unless authorized by enactment of a new law. (b) Prohibits the commissioner from transferring appropriations and funds in amounts over $100,000 across

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		agency accounts or programs, unless this is authorized by enactment of a new law. (c) Defines "state department" and "state agency." Provides an immediate effective date.
Section 25 (256.01, subd. 41) requires the commissioner and the MNsure Board by January 15, 2017, to develop a plan and timetable to ensure the implementation of qualifying life events and changes in circumstances are processed within 30 days of receiving a report of the qualifying life event or change in circumstances by persons who have been determined eligible for a public health care program or are enrolled in a qualified health plan through MNsure.	Senate requires plan and implementation timetable to be developed by 1-1-17; House requires implementation of procedures by 9-1-16. House defines qualifying life event and requires communication with, and training of, county staff. Differences in terminology, phrasing, and section coding.	**A3, § 7. Processing qualifying life events and changes in circumstances.** Amends § 62V.05, by adding subd. 4a. Requires the MNsure Board and commissioner of human services to jointly develop procedures to require qualifying life events and changes in circumstances to be processed within 30 days of the qualifying life event or change in circumstances being reported. Requires the procedures to be developed and implemented by September 1, 2016, and requires the commissioner to communicate the procedures to county staff and provide necessary training and guidance to county staff. Specifies what constitutes a qualifying life event or change in circumstances.
Section 26 (256B.04, subd. 14) includes allergen-reducing products to the items that the Commissioner of Human Services may use for volume-purchasing through competitive bidding and negotiations under chapter 16C.	Senate only (Related to Senate section 41)	
	House only	**A1, § 10. Additional notice to applicants.** Amends § 256B.042, by adding subd. 1a. Requires applications for MA to include a statement, prominently displayed, that the state may claim repayment from the estates of MA enrollees for the cost of medical care or premiums paid for care.
	House only	**A2, § 1. Improved oversight of MNsure eligibility determinations.** Adds § 256B.0562.

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		Subd. 1. Implementation of OLA findings. (a) Requires the commissioner of human services to ensure that MA and MinnesotaCare eligibility determinations through the MNsure information technology system fully implement the recommendations of the Office of Legislative Auditor (OLA) in reports 14-22 and 16-02. (b) Allows the commissioner to contract with a vendor for technical assistance in fully implementing the OLA report findings. (c) Requires the commissioner to coordinate implementation of this section with periodic data matching. (d) Requires the commissioner to use existing resources to implement this section. **Subd. 2. Duties of the commissioner.** (a) Lists the OLA report recommendations that the commissioner must fully implement. (b) Requires the commissioner to implement the OLA recommendations for MA and MinnesotaCare applications and renewals submitted on or after July 1, 2016. Requires the commissioner to submit quarterly reports to the legislative committees with jurisdiction over health and human services policy and finance that provide information on: (1) progress in implementing the OLA recommendations; (2) the number of applicants and enrollees affected by implementation;

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		and (3) savings to the state. Requires the quarterly report submitted October 1, 2016, to include a timetable for full implementation of the OLA recommendations. **Subd. 3. Office of Legislative Auditor.** Requires the legislative auditor to review each quarterly report for accuracy and review compliance by DHS with the OLA report recommendations. Requires the legislative auditor to notify legislative committee on whether or not these requirements are met. **Subd. 4. Special revenue account; use of savings.** (a) Establishes a medical assistance audit special revenue account in the general fund. Requires the commissioner to deposit into this account: (1) all savings from implementing the OLA recommendations; (2) all savings from implementing periodic data matching that are above the forecasted savings; and (3) all savings from implementing the vendor contract for eligibility verification under section 256B.0563, minus any payments made to the vendor under the revenue sharing agreement, (b) Requires the commissioner to provide a one-time payment increase to long-term care providers, once the balance in the fund is sufficient. (c) States that further expenditures from the account are subject to legislative authorization.

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		Effective date. Provides an immediate effective date.
	House only	**A2, § 2. Eligibility verification.** Adds § 256B.0563. **Subd. 1. Verification required; vendor contract.** (a) Requires the commissioner to ensure that MA and MinnesotaCare eligibility determinations through MNsure and agency eligibility determination systems include the computerized verification of income, residency, identity, and assets. (b) Directs the commissioner to contract with a vendor to verify the eligibility of all persons enrolled in MA and MinnesotaCare during a specified audit period. Provides an exemption from state procurement provisions related to the use of state employees, and any other law to the contrary. (c) States that the contract must require the vendor to comply with enrollee data privacy requirements and use encryption, and provide penalties for vendor noncompliance. (d) Requires the contract to include a revenue sharing agreement under which vendor compensation is limited to a portion of the savings resulting from the vendor's implementation of eligibility verification initiatives. (e) Requires the commissioner to use existing resources to fund any administrative and technology-related costs incurred as a result of implementing this section.

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		Subd. 2. Verification process; vendor duties. (a) Requires the verification process to include, but not be limited to, data matches of the name, date of birth, address, and Social Security number of enrollees against federal and state data sources, including the ACA federal hub. Requires the vendor, to the extent feasible, to incorporate in the verification process procedures that are compatible and coordinated with, and build upon or improve, procedures used by existing state systems. (b) Requires the vendor to notify the commissioner of preliminary determinations, and requires the commissioner to accept or reject determinations within 20 business days. States that the commissioner retains final authority over determinations and requires the vendor to keep a record of all preliminary determinations of ineligibility. (c) Requires the vendor to recommend to the commissioner an eligibility verification process that will allow ongoing verification of enrollee eligibility under the MNsure and state agency eligibility determination systems. (d) Requires the commissioner and the vendor to jointly submit an eligibility verification report to legislative committees. Specifies report criteria. (e) Provides that the vendor contract is for an initial one-year period, and allows the commissioner to renew the contract for up to three additional one-year periods,

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		and to require additional eligibility verification audits, if the commissioner or the legislative auditor determine that the MNsure and agency eligibility determination systems cannot effectively verify eligibility.
Section 27 (256B.057, subd. 13) requires the commissioner to establish a process for federally qualified health centers to determine presumptive eligibility for medical assistance for patients who are pregnant women or children under the age of two and have a basis for eligibility using the modified adjusted gross income methodology.	Senate only	
Section 28 (256B.059, subd. 1) strikes the definition of "spousal share" thereby removing the requirement that a community spouse be allowed to retain only half of the marital assets up to a limit. Under the new language, a community spouse will be able to retain 100 percent of marital assets up to a limit. This section is effective June 1, 2016.	Senate only	
Section 29 (256B.059, subd. 2) modifies when a couple's assets are assessed and the moment in time that is used in that assessment by eliminating the references to the first day of a continuous period of institutionalization. Under the new language, marital assets are assessed upon application for MA long-term services. This section is effective June 1, 2016.	Senate only	

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Section 30 (256B.059, subd. 3) sets the maximum value of assets a community spouse may retain at $119,220. The maximum current value is also $119,220 (after adjusting for inflation) but under the existing language, a community spouse can retain only one-half of the allowable marital assets, not 100 percent as is proposed under this section. This asset limit is subject to annual inflation adjustments. This section is effective June 1, 2016.	Senate only	
Section 31 (256B.059, subd. 5) eliminates unnecessary language. Under the new language, the assets available to a spouse receiving long-term care to pay for those services are all available assets after deducting the community spouse's asset allowance. This section is effective June 1, 2016.	Senate strikes references to the spousal share division and the requirement that asset evaluation take place following the first continuous period of institutionalization, and makes related changes. House provides that retirement and education related assets owned by the community spouse, in excess of the current law spousal share, may be retained by that spouse in cases of hardship.	**A1, § 11. Asset availability.** Amends Minnesota Statutes 2015 Supplement, § 256B.059, subd. 5. Allows an institutionalized spouse to maintain medical assistance eligibility when excess assets owned by the community spouse are retirement funds or funds protected for post-secondary education of a child under age 25. Provides that the retirement accounts are protected until the community spouse is eligible to withdraw funds without penalty. Requires that denial of eligibility must cause an undue hardship to the family. Provides that there shall not be an assignment of spousal support or a cause of action against the spouse for funds protected in retirement and college savings accounts. **Effective date.** Provides a June 1, 2016, effective date.

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Section 32 (256B.059, subd. 6) expands the definition of "institutionalized spouse" to include (1) effective June 1, 2016, a spouse applying after June 1, 2016, for HCBS waiver services (2) effective March 1, 2017, a spouse enrolled prior to June 1, 2016, to receive HCBS waiver services and (3) effective June 1, 2016, a spouse applying for community first services and supports.	Senate only	
Section 33 (256B.06, subd. 4) requires emergency medical assistance to cover kidney transplants for persons with end-stage renal disease, who are currently receiving dialysis services, and who are a potential candidate for a kidney transplant.	Senate only	
Section 34 (256B.0625, subd. 9c) specifies that medical assistance covers oral health assessments if the assessment uses the risk factors established by the commissioner and is conducted by a licensed dental provider in collaborative practice to identify possible signs of oral or systemic disease, malformation or injury, and the need for referral for diagnosis and treatment.	Senate only	
Section 35 (256B.0625, subd. 17a) increases the medical assistance payment rates by five percent for ambulance services provided by ambulance service providers whose base of operations is located outside the metropolitan counties and outside the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester, or within a municipality with a population of less than 1,000.	Senate requires managed care and county-based purchasing plans to pass on the full amount of the increase to providers. Technical difference in language specifying which providers are eligible for the increase (staff recommend Senate).	**A2, § 3. Payment for ambulance services.** Amends § 256B.0625, subd. 17a. Effective July 1, 2016, increases MA payment rates for ambulance services by 5 percent, for ambulance service providers that: (1) have a base of operations located outside the seven-county metropolitan area, and outside Duluth, Mankato, Moorhead, St. Cloud, and Rochester; or (2) have a base of operations located within a municipality with population of less than 1,000. Requires capitation payments to managed care and county-based

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		purchasing plans for ambulance services provided on or after January 1, 2017, to be adjusted to reflect the rate increase.
Section 36 (256B.0625, subd. 30) requires the commissioner to seek a section 1115 federal waiver in order to obtain enhanced federal financial participation at 100 percent federal match available to Indian health services facilities or tribal organization facilities for expenditures made for organizations that are dually certified under the Indian Health Care Improvement Act and as a federally qualified health center that provide services to eligible American Indians and Alaskan Natives.	Senate only	
Section 37 (256B.0625, subd. 31) specifies that the allergen products described in section 256B.0625, subdivision 65, shall be considered durable medical equipment.	Senate only	
Section 38 (256B.0625, subd. 34) specifies that the medical assistance payments to a dually certified facility under section 256B.0625, subd. 30, paragraph (j), shall be the encounter rate or a rate equivalent for services provided to American Indians and Alaska Native populations.	Senate only	
Section 39 (256B.0625, subd. 58) increases the payment rate for early and periodic screening, diagnosis, and treatment (EPSDT) screenings by five percent.	Senate only	
Section 40 (256B.0625, subd. 60a) adds community emergency medical technician (CEMT) services to the set of covered benefits under medical assistance by: • establishing CEMT services as a covered benefit;	Identical, except for technical differences in paragraph (c) (grammatical) and effective date (revisor notice). (Staff recommend Senate, with technical amendment to paragraph (c)).	**Community emergency medical technician services.** Amends § 256B.0625, by adding subd. 60a. (a) Provides medical assistance (MA) coverage of services provided by a community medical response emergency medical technician (CEMT) who is certified by the

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• establishing and describing a CEMT posthospital discharge visit as a CEMT service; • establishing and describing a CEMT safety evaluation visit as a CEMT service; and • establishing the provider rate for CEMT services.		Emergency Medical Services Regulatory Board under § 144E.275, subdivision 7, when the services are provided according to this subdivision. (b) Allows a CEMT to provide a hospital discharge visit when ordered by a treating physician. Specifies the criteria for a visit. (c) Allows CEMTs to provide safety evaluation visits to individuals who have repeat ambulance calls due to falls, have been discharged from a nursing home, or have been identified by their primary care provider as at risk for nursing home placement. Requires the visit to be ordered by a primary care provider in accordance with the individual's care plan. Specifies criteria for visits. (d) Requires CEMTs to be paid at $9.75 per 15 minute increment. Provides that a safety evaluation visit cannot be billed for the same day as a posthospital discharge visit for the same recipient. **Effective date.** Provides that the section is effective July 1, 2017, or upon federal approval, whichever is later.
Section 41 (256B.0625, subd. 65, paragraph (a) requires medical assistance to cover enhanced asthma care services and related products for children with poorly controlled asthma. Requires a child to meet the following criteria in order to be eligible for these services and products. The child must: 1. be under the age of 21; 2. have poorly controlled asthma;	Senate only	

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3. have received health care for asthma from a hospital emergency department at least one time in the past year or been hospitalized for the treatment of asthma at least once in the past year; and 4. received a referral for these services and products from a treating health care provider. **Paragraph (b**) lists the covered services and products, which includes: a home assessment conducted by a healthy homes specialist; targeted asthma education services; and allergen reducing products. **Paragraph (c)** states that a child is limited to one home assessment and one visit by a certified asthma educator on how to use and maintain the allergen reducing products. Permits an additional home assessment if the child moves into a new house, a new trigger enters the home, or the child's provider identifies a new allergy for the child. **Paragraph (d)** requires the commissioner to determine the frequency with which products may be replaced based on the reasonable expected lifetime of the product.		
	House only	**A2, § 5. Reimbursement under other state health care programs.** Amends § 256B.0644. Exempts dental providers providing services outside of the seven-county metropolitan area from the requirement that they participate as providers in MA and MinnesotaCare in order to participate as providers in the state employee health program, the public employees

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		insurance program, and other programs of health coverage (Rule 101).
Section 42 (256B.15, subd. 1) makes a conforming change to the estate recovery language by striking a reference to the "total" cost of medical assistance an individual receives.	Senate only	
Section 43 (256B.15, subd. 1a, paragraph e) retroactively modifies the circumstances under which the Commissioner of Human Services is permitted to file a claim against the estate of an individual who received medical assistance *while not residing in an institution*. For services rendered prior to January 1, 2014, a claim against an estate must be filed if: (1) a person received any medical assistance and the person was 55 years old or older at the time the service was rendered; or (2) the person at any age resided in an institution for six months or longer. For services rendered after January 1, 2014, a claim against an estate must be filed, but only if: (1) the person was 55 years old or older at the time the service was rendered and the services provided were nursing home services, home and community-based services, or related hospital and prescription drug benefits; or (2) the person at any age resided in an institution for six months or longer.	Similar – both bodies limit recovery from persons age 55 plus to long-term care services. Senate includes a cross-reference to claim amounts being limited under subd. 2 and provides that section is effective for claims not paid prior to 7-1-16. Also a technical difference in effective date (House specifies retroactive application). (Staff recommend House.)	**A1, § 12. Estates subject to claims.** Amends § 256B.15, subd. 1a. Limits claims against the estate of a person over 55 years of age who did not receive institutional services to the amount of medical assistance correctly paid on behalf of the individual prior to January 1, 2014. Clarifies that claims against the estates of individuals age 55 or older who received nursing facility services, home and community-based services, or related hospital and prescription drug benefits on or after January 1, 2014, are allowed. **Effective date.** Provides that this section is effective upon federal approval and applies retroactively to services rendered on or after January 1, 2014.

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	House only	**A1, § 13. Amending notices or liens arising out of notice.** Amends § 256B.15, by adding subd. 1l. Instructs state agencies to amend notices of potential claims and liens for notices filed on or after January 1, 2014, for medical assistance services provided to individuals age 55 and older who were not institutionalized. **Effective date.** Provides that this section is effective the day following final enactment.
Section 44 (256B.15, subd. 2 – Limitations on claims) specifies what costs may be included in a claim against an estate. For services rendered prior to January 1, 2014, a claim must include only (1) the total cost of medical assistance rendered after age 55, and (2) the total cost of medical assistance rendered at any age during a period of institutionalization. For services rendered after January 1, 2014, a claim must include only (1) the total cost of nursing home services, home and community-based services, and related hospital and prescription drug benefits rendered after age 55, and (2) the total cost of medical assistance rendered at any age during a period of institutionalization.	Similar. Technical difference in cross-reference (staff recommend House). Senate provides that section is effective for claims not paid prior to 7-1-16. Technical differences in cross-references (staff recommend Senate).	**A1, § 14. Limitations on claims.** Amends § 256B.15, subd. 2. Paragraph (a) adds language to clarify that this paragraph applies to services rendered prior to January 1, 2014. Paragraph (b) provides that claims for services rendered on or after January 1, 2014, must only include nursing facility services, home and community-based services, or related hospital and prescription drug benefits provided for individuals age 55 or older. States that claims must not include interest. **Effective date.** Provides that this section is effective upon federal approval and applies to services rendered on or after January 1, 2014.
Section 45 (256B.69, subd. 6) specifies that managed care plans and county-based purchasing plans must comply with chapter 62M and section 62Q.83, for purposes of delivering services under the prepaid medical assistance program.	Senate only	

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Section 46 (256B.76, subd. 1) increases the payment for primary care services by five percent when provided by a physician certified in family medicine, general internal medicine, pediatric medicine, or obstetric and gynecological medicine; or a physician assistant, advanced practice registered nurse, or physician other than a psychiatrist for whom at least 60 percent of the services for which they received payment under medical assistance or MinnesotaCare were for primary care evaluation and management services or vaccine administration services.	Senate only	
Section 47 (256B.76, subd. 2) Paragraph (l) specifies that effective January 1, 2017, payment rates for dental services provided outside the seven-county metropolitan area are increased by 9.65 percent. This replaces the payment rate increase for dental services that was passed last session that applied to dental services furnished by dental providers located outside of the seven-county metropolitan area. **Paragraph (m)** specifies that effective for services provided on or after July 1, 2016, payment rates for preventive dental services are increased by five percent.	Paragraph (l): House applies the 1-1-17 rural rate increase to rates in effect on 6-30-15 (both bodies sunset a rate increase that took effective 7-1-15). Senate requires plans to pass through increase to providers. Paragraph (m): Rate increase for preventive dental services is Senate only.	**A2, § 6. Dental reimbursement.** Amends § 256B.76, subd. 2. Effective January 1, 2017, increases MA payment rates by 9.65 percent above the rates in effect on June 30, 2015, for dental services provided outside the seven-county metropolitan area. States that the increase does not apply to state-operated dental clinics, federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2017, requires payments to managed care and county-based purchasing plans to reflect this payment increase. Also sunsets, on January 1, 2017, a rate increase for dental providers located outside the seven-county metropolitan area.
Section 48 (256B.76, subd. 4) Paragraph (a) modifies the medical assistance critical access dental payments from 35 percent to 37.5 percent, except as specified in paragraph (b). **Paragraph (b)** specifies that the critical access dental payment for dental clinics and dental groups that meet the critical access dental provider designation under	Senate increases critical access dental provider add-on to 37.5 percent of the rate that would otherwise be paid, effective 7-1-16. House increases the add-on to 36 percent on 7-1-16 and 37 percent on 7-1-17. Otherwise identical.	**A2, § 7. Critical access dental providers.** Amends § 256B.76, subd. 4. (a) Increases critical access dental provider payment rates, except for those set under paragraph (b), to 36 percent above the rate that would otherwise apply, effective July 1, 2016, and to 37 percent above the rate that would

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paragraph (d), clause (4), and is owned and operated by a health maintenance organization shall remain at 35 percent rate increase over what would otherwise be paid to the critical access provider. **Paragraph (c)** modifies the calculation used to determine the critical access dental payments. **Paragraph (d)** modifies the critical access dental provider designation so that the following dentists or dental clinics are included as critical access dental providers: nonprofit community clinics; hospital-based dental clinics owned and operated by a city, county, or former state hospital; dental clinics or dental groups owned and operated by a nonprofit corporation with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance or MinnesotaCare; and private practicing dentists if the dentist's office is located within the seven-county metropolitan area and more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare or is located outside the seven-county metropolitan and more than 25 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare.		otherwise apply, effective July 1, 2017. (The current rate enhancement is 35 percent.) (b) Retains the 35 percent enhanced critical access dental rate for dental clinics or dental groups owned and operated by an HMO that meets specified criteria. (c) Requires the critical dental provider payment rate for services provided to enrollees of a managed care or county-based purchasing plan to be calculated based on the plan's fee-for-service rate, rather than a capitated or cost-based payment rate. (d) Modifies criteria for critical access dental providers by: (1) including hospital-based dental clinics owned and operated by a former state hospital meeting specified criteria; and (2) broadening the criteria to include dentists in private practice located within the seven-county metropolitan area for whom more than 50 percent of patient encounters are with persons uninsured or covered by MA or MinnesotaCare and dentists located outside of the seven-county metropolitan area for whom more than 25 percent of patient encounters are with persons who are uninsured or covered by MA or MinnesotaCare. (Under current law, a dentist in private practice must be located in a health professional shortage area, meet the 50 percent patient encounter criteria, and provide a level of service critical to maintaining patient access.)
Section 49 (256B.761) increases payment rates for outpatient mental health services by five percent.	Senate only	

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Section 50 (256B.7625) increases the payment rates for prenatal and postpartum follow up home visits provided by public health nurses using evidence-based models to $140 per visit effective January 1, 2017.	Senate only	
Section 51 (256B.766) clarifies the medical assistance rate increase that was passed last year for durable medical equipment and supplies.	Identical, except House has effective date section that specifies retroactive intent; Senate does not have an effective date section. (Staff recommend inclusion of House effective date section.)	**Reimbursement for basic care services.** Amends § 256B.766. The amendment to paragraph (i) strikes language requiring the MA payment rate for durable medical equipment, prosthetics, orthotics, or supplies to be restored to the January 1, 2008, MA fee schedule. Also prohibits the commissioner from applying any MA payment reductions to durable medical equipment as a result of Medicare competitive bidding. A new paragraph (j) increases the MA payment rate for durable medical equipment, prosthetics, orthotics, or supplies that were subject to the Medicare 2008 competitive bid by 9.5 percent effective July 1, 2015. Further increases payment rates for durable medical equipment, prosthetics, orthotics, or supplies on the MA fee schedule, whether or not they were subject to the Medicare 2008 competitive bid, by 2.94 percent. Exempts the following from this paragraph: items subject to volume purchase, products subject to the preferred diabetic testing supply program, certain items provided to dually eligible recipients, and individually priced items. States that managed care and county-based purchasing plan payments shall not be increased to reflect the rate increases in this paragraph. **Effective date.** Provides a retroactive effective date of July 1, 2015.

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Section 52 (256L.01, subd. 1a) modifies the definition of child to an individual under the age of 21.	Senate only	
Section 53 (256L.01, subd. 5) modifies the definition of "income" to mean a household's current income, or if income fluctuates month to month, the income for the 12-month eligibility period.	Senate only	
Section 54 (256L.03, subd. 5) requires the commissioner to increase cost-sharing for covered services for enrollees with income greater than 200 percent, but not exceeding 250 percent so that the actuarial value for the MinnesotaCare benefit is 87 percent and for enrollees with income greater than 250 percent, but not exceeding 275 percent the actuarial value of the benefit is 80 percent.	Senate only	
Section 55 (256L.04, subd. 1) increases the income eligibility limit for MinnesotaCare from 200 percent to 275 percent for families with children.	Senate only	
Section 56 (256L.04, subd. 1a) requires individual and families applying to MinnesotaCare to provide a Social Security number if required under the federal regulations.	Senate only	
Section 57 (256L.04, subd. 2) makes it permissive for an individual or family to cooperate with the state to identify potentially liable third-party payers and assist the state in obtaining third-party payments or in establishing paternity and obtaining medical care support and payments for the child.	Senate only	
Section 58 (256L.04, subd. 7) increases the income eligibility limits for MinnesotaCare from 200 percent to 275 percent of federal poverty guidelines for single adults without children.	Senate only	

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Article 25: Health Care		Articles 1, 2, and 3
Section 59 (256L.04, subd. 7b) requires the commissioner to adjust the income limits annually each July 1 instead of January 1.	Senate only	
Section 60 (256L.05, subd. 3a) modifies the redetermination time period for MinnesotaCare so that the 12 month period begins the month of application and authorizes the commissioner to adjust the eligibility period for enrollees to implement renewals throughout the year.	Senate only	
Section 61 (256L.06, subd. 3) requires the commissioner to forgive the past due premium for individuals who are disenrolled for nonpayment of premiums before issuing a premium invoice for the fourth month following disenrollment.	Senate only	
Section 62 (256L.07 subd. 1) modifies the period in which disenrollment begins for individuals whose income increases above the income eligibility limit to the last day of the calendar month in which the commissioner sends advance notice in accordance with federal regulations.	Senate only	
Section 63 (26L.11, subd. 7) increases the critical access dental payments for MinnesotaCare from 30 percent to 32.5 percent above the payment the provider would otherwise be paid, except for the critical access dental providers described in section 256B.76, subdivision 4, paragraph (b), in which the payment shall remain at 30 percent above the payment the provider would otherwise be paid.	Senate only	

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Article 25: Health Care		Articles 1, 2, and 3
Section 64 (256L.15, subd. 1) requires the commissioner to accept an individual's attestation of the individual's status as an American Indian as verification until the federal government approves an electronic data source that purpose.	Senate only	
Section 65 (256L.15, subd. 2) requires the commissioner of human services, in consultation with the commissioners of health and commerce and the executive director of MNsure, to seek all necessary federal waiver authority to design and operate a seamless and sustainable health coverage continuum that reduces barriers, eases transition, and ensures access to comprehensive and affordable health care coverage. The waiver shall include proposals to expand MinnesotaCare income eligibility to 275 percent of federal poverty guidelines; offer continuous eligibility for families and children; address the "family glitch;" establish a MinnesotaCare public option; and replace the annual open enrollment period with an alternative.	Senate only	
Section 66 (Federal Waiver) requires the commissioner of human services, in consultation with the commissioners of health and commerce and the executive director of MNsure, to seek all necessary federal waiver authority to design and operate a seamless and sustainable health coverage continuum that reduces barriers, eases transition, and ensures access to comprehensive and affordable health care coverage. The waiver shall include proposals to expand MinnesotaCare income eligibility to 275 percent of federal poverty guidelines; offer continuous eligibility for families and children; address the "family glitch;" establish a MinnesotaCare public option;	Senate waiver would seek necessary federal authority to design and operate a seamless and sustainable health coverage continuum by: requesting to expand MinnesotaCare eligibility to 275 percent FPG; providing continuous 12-month MA eligibility for children and families; allowing certain persons with employer subsidized coverage to enroll in MinnesotaCare or access premium tax credits and cost sharing subsidies ("family glitch"); establishing a MinnesotaCare public option for persons with income over the MinnesotaCare income limit; and allowing for an alternative open enrollment	**A3, § 14. Federal waiver.** Amends § 256L.02, by adding subd. 7. Directs the commissioner of human services to apply for an innovation waiver under section 1332 of the Affordable Care Act, or any other applicable federal waiver, to allow persons eligible for MinnesotaCare to decline MinnesotaCare coverage and instead access advanced premium tax credits and cost-sharing reductions by purchasing qualified health plans, either through MNsure or outside of MNsure through health plan companies. Requires the waiver request to be submitted within nine months of the effective date of this provision. Requires the commissioner to coordinate the waiver request with the waiver requested by the

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Article 25: Health Care		Articles 1, 2, and 3
and replace the annual open enrollment period with an alternative.	period for the individual health plan market. House waiver (section 14) would allow persons to decline MinnesotaCare coverage and obtain premium tax credits and cost-sharing reductions for qualified health plans through MNsure or outside of MNsure. House waiver (section 15) would replace MNsure with a federal-state eligibility determination system, under which enrollment and eligibility for MA and MinnesotaCare would be conducted by DHS, and enrollment and eligibility for qualified health plans, premium tax credits, and cost-sharing reductions would be conducted by the federal exchange. House would also establish an asset test for adults without children under MA and MinnesotaCare.	commissioner of commerce to allow individuals to purchase qualified health plans outside of MNsure directly from health plan companies, and receive advanced premium tax credits and cost-sharing reductions (required by Laws 2015, chapter 71, article 12, section 8). Requires the commissioner of human services to submit a draft waiver proposal to the MNsure board and legislative committees at least 30 days before submitting the final waiver proposal to the federal government, and to notify the board and legislative committees of any federal decision or action. If federal approval is granted, requires the commissioner to submit to the legislature draft legislation and fiscal estimates necessary to implement the proposal. **Effective date.** Provides an immediate effective date. **A 3, § 15. Federal-state eligibility determination and enrollment system for insurance affordability programs.** Directs the commissioner of human services to seek a federal waiver to establish a federal-state eligibility determination and enrollment system. **Subd. 1. Waiver request.** (a) Requires the commissioner of human services, in consultation with the MNsure board and the commissioners of commerce and health, to apply for a federal section 1332 innovation waiver, or any other applicable waiver, to establish a federal-state eligibility determination and enrollment system for state insurance affordability programs, for coverage beginning January 1, 2018.

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		States that the system shall take the place of MNsure. Specifies that under the system, eligibility determinations and enrollment for MA and MinnesotaCare shall be conducted by the commissioner, and eligibility determinations and enrollment for qualified health plans, advanced premium tax credits, and cost-sharing reductions shall be conducted by the federally-facilitated marketplace. (b) Defines "state insurance affordability programs." (c) Requires the system to incorporate an asset test for persons who qualify as adults without children under MA or MinnesotaCare. Specifies the asset limit as $10,000 in total net assets for a household of one and $20,000 for a household of two or more. **Subd. 2. Requirements of waiver application.** Requires the commissioner, in designing the eligibility determination and enrollment system and developing the waiver application, to: (1) incorporate, where appropriate and cost-effective, elements of the MNsure and DHS eligibility determination systems; (2) coordinate the waiver request with the waiver requests required by section 256L.02, subdivision 7 (allowing persons to decline MinnesotaCare and access tax credits and cost-sharing reductions) and Laws 2015, chapter 71, article 12, section 8 (allowing purchase of qualified health plans outside of MNsure and access to tax credits and cost-sharing reductions); (3) regularly consult with stakeholder groups; and (4) seek all

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Article 25: Health Care		**Articles 1, 2, and 3**
		available federal grants and funds for planning and development. **Subd. 3. Vendor contract; use of existing resources.** Requires the commissioner, in consultation with MN.IT, to contract with a vendor for technical assistance. Requires the commissioner to use existing resources in developing the waiver request and contracting for technical assistance. **Subd. 4. Reports to legislative committees.** Requires the commissioner to report to legislative committees, by January 1, 2017, on progress in seeking the waiver, and to notify legislative committees of any federal decision related to the waiver request. **Effective date.** Provides an immediate effective date.
Section 67 (Direction to the Commissioner; Notice) requires the Department of Human Services within 90 days of enactment to notify anyone who received medical assistance non long-term care services of the amendments to the estate recovery language in this bill.	Senate only	
Section 68 requires the Commissioner of Management and Budget to develop a request for information to consider the feasibility for a private vendor to provide the technology functions for the individual market and small business health options program (SHOP) market currently provided by MNsure.	Senate only	

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Article 25: Health Care		Articles 1, 2, and 3
	House only	**A2, § 9. Prohibition on use of funds.** **Subd. 1. Use of funds.** Prohibits funding for state-sponsored health programs that are administered by the commissioner of human services from being used for funding abortions except to the extent necessary for continued participation in a federal program. (The health care programs administered by the commissioner of human services are medical assistance and MinnesotaCare.) Defines abortion. **Subd. 2. Severability.** Allows for severability of any one or more provisions of this section if any part is found to be unconstitutional.
	House only	**A3, § 16. Revisor's instruction.** Authorizes the revisor of statutes to change cross-references to statutes and rules that are repealed in this article, and to make any necessary technical changes to preserve the meaning of the text.

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Article 25: Health Care		Articles 1, 2, and 3
Section 69 (Repealer.) **Paragraph (a)** repeals obsolete language concerning the implementation of the rules governing the treatment of marital assets when a spouse is institutionalized effective June 1, 2016. **Paragraph (b)** repeals sections 256L.04, subd. 2a (application for other benefits); 256L.04, subd. 8 (applicants potentially eligible for medical assistance); 256L.22, 256L.24; 256L.26; 256L.28 (Children's Health program) effective the day following final enactment, effective the day following final enactment.	Senate repeals provisions related to treatment of marital assets under MA and provisions related to MinnesotaCare; House repeals provisions establishing and governing MNsure, contingent upon federal waiver approval.	**A3, § 17. Repealer.** Repeals the statutes and rules that establish and govern MNsure. Provides that this section is effective upon approval of the waiver request to establish and operate a federal-state eligibility determination and enrollment system, or January 1, 2018, whichever is later.

Article 26: Health Department		Article 4: Health Department
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.	

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Article 26: Health Department		Article 4: Health Department
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, 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	Senate only.	

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Article 26: Health Department		Article 4: Health Department
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 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.		

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Article 26: Health Department		Article 4: Health Department
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, 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	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). • 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.	**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 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.

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Article 26: Health Department		Article 4: Health Department
requirements for the release of health records as required under the Minnesota Health Records Act.		
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.	
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.	

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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. • One technical difference (staff recommend Senate).	**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 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.

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		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.
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).

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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.
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

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		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 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

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		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 attached to or next to the location where home care services are also provided.

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		• 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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Article 26: Health Department		Article 4: Health Department
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;

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

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		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.
	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.

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		Subd. 3. Federal funds. Requires the commissioner to apply for any available federal grant funds for the program.
	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.)

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	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.
	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.

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	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.
	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

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		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 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	Senate only.	

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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.		
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.

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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.
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.	

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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.

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Section 1 (146C.01) defines the following terms: advisory council; code of ethics; commissioner; common languages; interpreting standards of practice; registry; remote interpretation; spoken language health care interpreter; and spoken language interpreting services.	Identical. Senate has placed the statutes regulating spoken language health care interpreters in a new chapter of law (146C). The House includes in chapter 148. (This difference is throughout these sections). Staff recommends Senate.	**Sec. 10. Definitions.** Creates § 148.9981. Defines the terms "advisory council," "code of ethics," "commissioner," "interpreting standards of practice," "registry," "remote interpretation," "spoken language health care interpreter" or "interpreter," and "spoken language interpreting services."
Section 2 (146C.03) establishes a tiered registry system for spoken language health care interpreters. **Subdivision 1, paragraph (a)** requires the Commissioner of Health to establish by July 1, 2017, a registry for spoken language health care interpreters. Specifies that the registry must contain four separate tiers based on different qualification standards for education and training. **Paragraph (b)** requires any individual who wants to be on the registry to submit an application to the commissioner along with the applicable fees. Specifies what the application must include. **Paragraph (c)** requires the commissioner to determine if the applicant meets the requirements for the applicable registry tier and authorizes the commissioner to request additional information from the applicant. Requires the commissioner to notify the applicant of the action taken on the application and if the applicant is denied the grounds for denial.	Identical, except Senate subdivision 3 includes the updated name of an examining board. Staff recommends Senate.	**Sec. 11. Registry.** Creates § 148.9982. **Subdivision 1. Establishment.** Paragraph (a) requires the commissioner of health to establish a registry for spoken language health care interpreters by July 1, 2017. Requires the registry to have four tiers based on qualification standards. Paragraph (b) requires an individual who wants to be listed on the registry to submit an application to the commissioner. Paragraph (c) instructs the commissioner to determine if the applicant meets the requirements for the applicable registry tier and to notify the applicant of the action taken on the application. Paragraph (d) provides that if the commissioner denies the application, the applicant may apply for a lower tier or may reapply for the same tier at a later date. Paragraph (e) allows applicants who qualify for different tiers for different language to submit only one application.

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Paragraph (d) specifies that if the application is denied, the applicant may apply for a lower tier or may reapply for the same tier at a later date. **Paragraph (e)** specifies that if an applicant qualifies for different tiers for different languages, the applicant is only required to submit one application and submit the fee associated with the highest tier for which the applicant is applying. **Paragraph (f)** authorizes the commissioner to request additional information from an applicant as deemed necessary. **Subdivision 2** describes the requirements for the tier 1 registry. **Subdivision 3** describes the requirements for the tier 2 registry. **Subdivision 4** describes the requirements for the tier 3 registry. **Subdivision 5** describes the requirements for the tier 4 registry. **Subdivision 6** requires a registered interpreter to inform the commissioner in writing within 30 days if the interpreter changes their name, address, or email address. Specifies that any notice or other correspondence mailed to the interpreter's address or e-mail on file with the commissioner shall be considered received by the interpreter.		Paragraph (f) allows the commissioner to request additional information from the applicant. **Subd. 2. Tier 1 requirements.** Provides that an individual must be at least 18 years of age, pass an examination on basic medical terminology in English, pass an examination on interpreter ethics and standards of practice, and affirm that the applicant has read to code of ethics and standards of practice and will abide by them. **Subd. 3. Tier 2 requirements.** In addition to the requirements of subdivision 2, between July 1, 2017, and June 30, 2018, the individual must provide proof of completion of a training program for medical interpreters that is at least 40 hours in length. Establishes training requirements effective July 1, 2018. **Subd. 4. Tier 3 requirements.** In addition to the requirements of subdivision 2, an applicant must have national certification in health care interpreting that does not include a language proficiency component, or provide proof of successfully completing an interpreting certification program from an accredited U.S. academic institution that is at least 18 semester credits. **Subd. 5. Tier 4 requirements.** In addition to the requirements of subdivision 2, an applicant must have national certification in health care interpreting that includes language proficiency in a non-English

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Subdivision 7 specifies that all information submitted to the commissioner by an applicant is classified in accordance with section 13.41.		language, or has an associate's degree or higher in interpreting and has achieved a score of "advanced mid" or higher. The degree must include at least three semester credits of medical terminology or medical interpreting. Allows the commissioner, in consultation with the advisory committee, to approve alternate means of achieving proficiency or degrees from foreign institutions. **Subd. 6. Change of name and address.** Requires registrants to notify the commissioner in writing within 30 days of any changes to their name, address, or email address. **Subd. 7. Data.** Provides that applicant and registrant data shall be maintained according to § 13.41.
Section 3 (146C.05) establishes the registry renewal process. **Subdivision 1** specifies that the registry period is valid for one year. To renew, an interpreter must submit a renewal application, a continuing education report, and the required fees. **Subdivision 2** requires the commissioner to send out a renewal notice to the interpreter's last known address on file with the commissioner 60 days before the registry expiration date. Requires the interpreter to meet the deadline for renewal for continuous inclusion on the registry even if the interpreter did not receive the renewal notice. Specifies that a renewal application	Identical.	**Sec. 12. Renewal.** Creates § 148.9983. **Subd. 1. Registry period.** Provides that listing on the registry is valid for one year. Requires interpreters to submit a renewal application, a continuing education report, and the required fees. **Subd. 2. Notice.** Requires the commissioner to send out a renewal notice 60 days before registry expiration. Requires that the renewal be received by the commissioner or postmarked at least 30 days prior to the registry expiration date.

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must be received by the commissioner or postmarked at least 30 days before the expiration date. **Subdivision 3** requires the renewal application to include the late fee if submitted after the deadline. **Subdivision 4** requires an interpreter whose registry listing has lapsed for more than one year to submit a new application to be listed on the registry.		**Subd. 3. Late fee.** Requires the interpreter to pay a late fee when a renewal application is submitted after the renewal deadline. **Subd. 4. Lapse in renewal.** Provides that an interpreter must submit a new application if the interpreter's registry listing has been expired for one year or more.
Section 4 (146C.07) describes prohibited conduct and disciplinary actions that may be taken by the commissioner. **Subdivision 1** describes the prohibited conduct that if violated, may be grounds for disciplinary action. **Subdivision 2** authorizes the commissioner to initiate an investigation upon receiving a complaint alleging a violation. **Subdivision 3** lists the disciplinary action the commissioner may take. **Subdivision 4** permits interpreters who have been removed from the registry or have had their practice suspended to request and provide justification for reinstatement following a period of suspension. The interpreter must meet the requirements of these sections or any other condition imposed by the commissioner before the interpreter may be listed on the registry or have the right to practice reinstated.	Identical.	**Sec. 13. Disciplinary actions; oversight of complaints.** Creates § 148.9884. **Subd. 1. Prohibited conduct.** Lists the grounds for disciplinary or corrective action. **Subd. 2. Complaints.** Allows the commissioner to investigate complaints. Requires the commissioner to follow the procedures followed by the health-related licensing boards for complaint investigations and hearings. **Subd. 3. Disciplinary actions.** Lists the types of actions that may be taken by the commissioner. **Subd. 4. Reinstatement requirements after disciplinary action.** Allows an interpreter who has been removed from the registry or had their practice suspended to request reinstatement.

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Section 5 (146C.09) specifies the continuing education requirements. **Subdivision 1** requires the advisory council to approve continuing education courses and training. Specifies the numbers of continuing education hours that an interpreter must complete for each tier during the registry period. **Subdivision 2** requires the interpreter to submit with a renewal application a continuing education report on a form provided by the commissioner that indicates that the interpreter has met the required hours. Authorizes the commissioner and the advisory council to audit a percentage of the reports based on a random selection.	Identical.	**Sec. 14. Continuing education.** Creates § 148.9985. **Subd. 1. Course approval.** Requires the advisory council to approve continuing education course and training. Allows a course, not approved by the council, to be submitted for credit, but permits the commissioner to disallow credit for the course. Lists the number of continuing education required for each tier. **Subd. 2. Continuing education verification.** Requires each interpreter to submit a continuing education report form along with the renewal application. **Subd. 3. Audit.** Allows the commissioner or advisory council to conduct a random audit of continuing education reports.
Section 6 (146C.11) establishes the spoken language health care interpreter advisory council. Describes the makeup of the council and their duties.	Identical.	**Sec. 15. Spoken language health care interpreter advisory council.** Creates § 148.9986. **Subd. 1. Establishment.** Instructs the commissioner to appoint a ten member advisory council. **Subd. 2. Organization.** Requires the council to be organized and administered under section 15.059. **Subd. 3. Duties.** Lists the duties of the council.

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Section 7 (146C.13) establishes the applicable fees. Specifies that the fees are nonrefundable and shall be deposited in the state government special revenue fund.	Identical.	**Sec. 16. Fees.** Creates § 148.9987. Fees amounts for initial and renewal applications and late fees are not specified. Provides that fees are nonrefundable and are to be deposited in the state government special revenue fund.
Section 8 (147F.01) defines the following terms: ABGC, ABMG, ACGC, board, eligible status, genetic counseling, genetic counselor, licensed physician, NSGC, qualified supervisor, supervisee, and supervision.	Technical differences, otherwise identical. (Technical difference throughout these sections). Staff recommends Senate.	**Sec. 1. Definitions.** Creates § 147F.01. Defines the following terms as used in this practice act: "ABGG," "ABMG," "ACGC," "board," "eligible status," "genetic counseling," "genetic counselor," "licensed physician," "NSGC," "qualified supervisor," "supervisee," and "supervision."
Section 9 (147F.03) describes the scope of practice for the practice of genetic counseling by a licensed genetic counselor.	Identical.	**Sec. 2. Scope of practice.** Creates § 147F.03. Lists the type of services provided by a licensed genetic counselor.
Section 10 (147F.05) prohibits unlicensed practice and establishes title protection. **Subdivision 1** prohibits an individual from using the title of genetic counselor, licensed genetic counselor, gene counselor, genetic consultant, genetic assistant, genetic associate or any words, letters, abbreviations, or insignia that indicates or implies that the individual is eligible for licensure as a genetic counselor unless the individual has been licensed under the chapter. **Subdivision 2** prohibits an individual from practicing genetic counseling unless the individual is licensed as a genetic counselor under this chapter, effective January 1, 2018. **Subdivision 3, paragraph (a)** specifies that nothing in this chapter prohibits an individual who is duly licensed	Identical.	**Sec. 3. Unlicensed practice prohibited; protected titles and restrictions on use.** Creates § 147F.05. **Subd. 1. Protected titles.** Prohibits use of the titles "genetic counselor, "licensed genetic counselor," "gene counselor," "genetic consultant," "genetic assistant," or "genetic associate" unless the individual is licensed as a genetic counselor. **Subd. 2. Unlicensed practice prohibited.** Prohibits the practice of genetic counseling unless licensed as a genetic counselor, or subject to an exception as provided in subdivision 3 of this section. **Subd. 3. Other practitioners.** Paragraph (a) provides nothing in this practice act shall limit the

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in this state to practice any profession or occupation or to perform any act that falls within the scope of practice of that occupation or profession. **Paragraph (b)** specifies that a license is not required for individuals who are employed by the federal government or federal agency; students or interns currently enrolled in an accredited genetic counseling program or who have graduated within the past six months; a visiting certified genetic counselor working as a consultant, or are licensed to practice medicine under chapter 147. **Subdivision 4** states that any individual who violates this section is guilty of a misdemeanor and is subject to sanctions under section 214.11.		practice of other licensed professionals who are operating within their scope of practice. Paragraph (b) provides that a license is not required for individuals who are employed by the federal government or federal agency, students enrolled in an accredited genetic counseling program or students who have graduated within the past six months and are scheduled to take the certification examination, a visiting certified genetic counselor working as a consultant, or are licensed to practice medicine under chapter 147. **Subd. 4. Sanctions.** Provides that violation of this section is a misdemeanor and is subject to sanctions under section 214.11.
Section 11 (147F.07) requirements for licensure. **Subdivision 1** establishes the general requirements for licensure. **Subdivision 2** establishes the requirements for licensure by reciprocity. **Subdivision 3** authorizes the board to grant a license to an individual who does not meet the certification requirements in subdivision 1 but who has been employed as a genetic counselor for a minimum of ten years and provides to the board no later than February 1, 2017, the following documentation: proof of a master's degree of higher degree in genetics or related field from an accredited institution; proof that the individual has	Subdivisions 1, 2, 4, and 5 are identical. In subdivision 3, the Senate requires applicants for a license by equivalency to submit documentation by January 1, 2018. The House language has the date of February 1, 2018. The Senate expiration date for the subdivision is January 1, 2018, and the House expiration is February 1, 2018.	**Sec. 4. Licensure requirements.** Creates § 147F.07. **Subd. 1. General requirements for licensure.** Requires applicants to submit a completed application along with the required fees, evidence of graduation from an accredited genetic counseling program, valid and current certification from a national certification program, and additional information requested by the board. **Subd. 2. Licensure by reciprocity.** Requires an applicant to hold a current genetic counselor or medical geneticist registration or license in another jurisdiction whose standards meet or exceed those of Minnesota, and to meet specified requirements in subdivision 1.

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never failed a certification exam; three letters of recommendation; and documentation of the completion of 100 hours of approved continuing education within the past five years. This subdivision expires February 1, 2017. **Subdivision 4** states that a license is valid for one year from the date of issuance. **Subdivision 5** establishes the requirements for license renewal.		Requires the applicant to provide letters of verification from each jurisdiction in which the applicant is registered or licensed. **Subd. 3. Licensure by equivalency.** Allows the board to grant a license to an individual who does not meet the certification requirements in subdivision 1, but who has been employed as a genetic counselor for a minimum of ten years and provides specified documentation to the board. Provides that this subdivision expires February 1, 2018. **Subd. 4. License expiration.** Provides that a license is valid for one year. **Subd. 5. License renewal.** Requires a genetic counselor to submit a renewal application and the required fee, evidence of compliance with continuing education requirements, and any additional information requested by the board.
Section 12 (147F.09) requires the board to take action on each application submitted and to provide written notice to the applicant of the action taken, the grounds for denying the license if the license was denied, and the applicant's right to review the board's decision to deny the license. Permits the board to investigate information provided by the applicant. Permits an applicant whose license application was denied to make a written request to the board within 30 days of the notice, appear before the advisory council, and for the	Identical.	**Sec. 5. Board action on applications for licensure.** Creates § 147F.09. Requires the board to take action on each application submitted and provide written notice to the applicant of the action taken. Allows the board to investigate information provided by an applicant. Provides that if the board denies a license, grounds for denial must be disclosed to the applicant along with the applicant's right for a review of the board's decision.

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advisory council to review the board's decision and make a recommendation to the board as to whether the denial should be affirmed. Permits one request for review per licensure period.		
Section 13 (147F.11) requires a licensed genetic counselor to complete a minimum of 25 hours of approved continuing educations units during a two-year period. Permits the board to grant a variance to these continuing education requirements if the licensee can demonstrate to the satisfaction of the board that the licensee was unable to complete the required number of units during the period. The board may extend the time period for completing the required number of units but may not allow the licensee to complete less than the required number.	Identical.	**Sec. 6. Continuing education requirements.** Creates § 147F.11. Paragraph (a) requires genetic counselors to complete a minimum of 25 hours of approved continuing education units during each two-year period. Paragraph (b) allows the board to grant a variance to the continuing education requirements.
Section 14 (147F.13) specifies that licensed genetic counselors and applicants are subject to the disciplinary actions and reporting requirements of sections 147.091 to 147.162. (Board of Medical Practice)	Identical.	**Sec. 7. Discipline; reporting.** Creates § 147F.13. Provides that disciplinary action and reporting requirements are subject to sections 147.091 to 147.162, disciplinary provisions of the Board of Medical Practice.
Section 15 (147F.15) establishes the Licensed Genetic Counselor Advisory Council.	Subdivisions 1, 3, and 4 are identical. In subdivision 2, the Senate exempts the advisory council from the membership term requirements of section 15.059, subd. 2, and specifies the terms of the advisory council members. The House provides that the council shall be organized under section 15.059. (Staff recommends House with amendments.)	**Sec. 8. Licensed genetic counselor advisory council.** Creates § 147F.15. **Subd. 1. Membership.** Requires the board to appoint a five member council. One member must be a licensed physician, one a public member, and three licensed genetic counselors. **Subd. 2. Organization.** Provides that section 15.059 governs the organization and administration of the council.

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		Subd. 3. Duties. Requires the council to advise the board on licensing standards and complaints, enforcement of the genetic counselor practice act, and provide for distribution of information on genetic counselor practice standards. **Subd. 4. Expiration.** Provides that the council does not expire.
Section 16 (147F.17) establishes fees for the license application, initial licensure and annual renewal, and late fee. Permits the board to prorate the initial license fee. Specifies that the fees are nonrefundable and that all fees collected are to be deposited to the state government special revenue fund.	Subdivisions 2 to 5 are identical. In subdivision 1, the House has a fee for a provisional license, the Senate does not. (No provisional license, so staff recommends Senate)	**Sec. 9. Fees.** Creates § 147F.17. Establishes fees for license application, initial license and annual renewal, provisional license, and a late fee. Allows the board to prorate fees. Provides that fees are nonrefundable. Requires fees to be deposited in the state government special revenue fund.
Section 17 (148.9801) specifies that nothing in these sections prohibits an individual from providing breastfeeding education and support services and does not require the individual be licensed under these sections.	Senate only section.	
Section 18 (148.9802) defines the following terms: biennial licensure period; breastfeeding education and support services; certified lactation counselor, advanced lactation consultant, or advanced nurse lactation consultant; clinical lactation services; commissioner; credential; International Board-Certified Lactation Consultant; license or licensed; licensed lactation care provider; licensee; licensure by equivalency; licensure by reciprocity; and protected title.	Senate only section.	
Section 19 (148.9803) prohibits unlicensed practice and restricts the use of protected titles.	Senate only section.	

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Subdivision 1 prohibits an individual from engaging in the practice of clinical lactation services unless the individual is licensed as a licensed lactation care provider under these sections, effective July 1, 2017. **Subdivision 2, paragraph (a),** prohibits an individual from using the phrases "licensed lactation consultant" or "licensed International Board-Certified Lactation Consultant;" unless the individual is licensed under these sections and possesses a credential from the International Board of Lactation Consultant Examiners. **Paragraph (b)** prohibits an individual from using phrases "licensed certification lactation counselor," "certified lactation counselor," "licensed advanced lactation consultant," "advanced lactation consultant," "licensed advanced nurse lactation consultant," "advanced nurse lactation consultant," "licensed lactation counselor," or "licensed lactation consultant," unless the individual is licensed under those sections and possesses a credential from the Academy of Lactation Policy and Practice of the Healthy Children Project, Inc. **Subdivision 3** exempts the following individuals from having to be licensed: a person employed as a lactation consultant by the federal government or federal agency; a student participating in supervised fieldwork or supervised coursework; under specified conditions a person visiting and then leaving the state and performing clinical lactation services while in the state; a dentist, physician, osteopathic physician, physician assistant,		

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nurse, dietitian, or midwife when providing clinical lactation services incidental to the practice of their profession if they do not use the protected titles; a public employee who is acting within the scope of their employment; or a volunteer providing clinical lactation services if the volunteer does not use the protected titles, charges no fees for their service, and receives no compensation except for administrative services. **Subdivision 4** specifies that an individual may be subject to sanctions or other action if the individual practices clinical lactation services or represents that they are a licensed lactation care provider without being licensed under these sections. **Subdivision 5** specifies that these sections do not prohibit a licensed individual acting within the scope of their occupation or profession from performing any act that falls within the scope of practice of their profession or occupation.		
Section 20 (148.9804) authorizes the commissioner to impose a civil penalty for each violation.	Senate only section.	
Section 21 (148.9806) specifies the licensure requirements. **Subdivision 1** states that an applicant for licensure must have a current credential from the International Board of Lactation Consultant Examiners, the International Board of Lactation Consultant Examiners, the Academy of Lactation Policy and Practice of the Healthy Children Project, Inc., or another jurisdiction whose standards are	Senate only section.	

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equivalent to or exceed the requirements in these sections as determined by the commissioner; submit a completed application; submit the applicable fees; sign a statement that the information of the application is correct; sign a waiver authorizing the commissioner to obtain access to the applicant's records in this or another state; submit any additional information requested by the commissioner; and submit any additional information required for licensure by equivalency or reciprocity. **Subdivision 2** states that any applicant who is credentialed by the International Board of Lactation Consultant Examiners as an International Board-Certified lactation consultant may be eligible for licensure by equivalency. States that the commissioner may deny licensure based on disciplinary grounds. Requires applicants to provide verified documentation indicating that the applicant is credentialed by the International Board of Lactation Consultant Examiners as an International Board-Certified Lactation Consultant and to provide the commissioner with a waiver authorizing access to the applicant's records. **Subdivision 3** states that any applicant who holds a current credential as a licensed lactation consultant, lactation care provider, or licensed lactation counselor in another state or territory of the US whose standards are equivalent or exceeds the requirements for licensure under these sections may be eligible for licensure by reciprocity. States that the commissioner may deny		

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licensure based on disciplinary grounds. Requires the applicants to provide verification of the credentials to the commissioner. **Subdivision 4** requires the commissioner to approve, approve with conditions, or deny licensure. Authorizes the commissioner to investigate the information provided to determine if the information is accurate and complete. Requires the commissioner to notify an applicant of action taken on the application and if licensure is denied or approved with conditions, the grounds for this decision. If an applicant is denied licensure or granted licensure with conditions, the applicant may make a written request for reconsideration within 30 days of the determination and may submit any information the applicant wants the commissioner to consider. Requires the commissioner to determine whether the original determination should be affirmed or modified. Permits the applicant no more than one request in any one biennial licensure period for reconsideration of the commissioner's determination.		
Section 22 (148.9807) establishes licensure renewal requirements. **Subdivision 1** requires the licensee to submit a completed and signed application for renewal; the renewal fee; proof that the licensee is currently credentialed; and any additional information requested by the commissioner.	Senate only section.	

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Subdivision 2 specifies that licenses must be renewed every two years. Requires that the application for renewal be received by the commissioner at least 30 calendar days before the expiration date printed on the license. States that an application received within 30 days of the expiration date but before the expiration date must be accompanied by a late fee in addition to the renewal fee. Applications received after the expiration date shall not be accepted and applicants must meet the licensure requirements under section 148.9808. **Subdivision 3** requires the commissioner to notify the licensee at least 60 days before the expiration date. Failure to receive notification does not relieve the licensee of the obligation to meet the renewal deadline and other renewal requirements.		
Section 23 (148.9808) specifies the licensure renewal requirements if the application for licensure renewal is received after the expiration date.	Senate only section.	
Section 24 (148.9809) requires a licensee to notify the commissioner of any change in name, address, business address, and telephone number or employment within 30 days of the change.	Senate only section.	

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Section 25 (148.9810) requires that in the absence of a physician referral or prior authorization, a licensed lactation care provider must provide a client with written notification that the client may be obligated for partial or full payment for the clinical lactation services provided. Permits this notice to be in a nonwritten format if necessary to accommodate the physical condition of the client or client's guardian.	Senate only section.	
Section 26 (148.9811) establishes the various licensure fees, including duplicate license fees, late fees, and penalty fees.	Senate only section.	
Section 27 (148.9812) establishes the grounds for disciplinary action and the disciplinary action that may be taken by the commissioner. **Subdivision 1** lists the types of conduct that are grounds for disciplinary action. **Subdivision 2** requires the commissioner to comply with the procedures for the health-related licensing boards for receipt, investigation, and hearing complaints as provided in section 214.10. **Subdivision 3** lists the types of disciplinary action that may be taken by the commissioner. **Subdivision 4** requires the licensee to cease using the protected title if disciplinary action imposed prevents the individual from providing clinical lactation services. **Subdivision 5** permits an individual whose license has been suspended to request reinstatement.	Senate only section.	

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Subdivision 6 requires the commissioner to contract with the health professional services program to provide services to licensees.		
Section 28 (148.982) defines the following terms: “advertise,” “advisory council,” “applicant,” “board,” “client,” “competency exam,” “contact hour,” “credential,” “health care provider,” “massage and bodywork therapy,” “municipality,” “physical agent modality,” “practice of massage and bodywork therapy,” “professional organization,” “registered massage and bodywork therapist or registrant,” and “state.”	Senate only section.	
Section 29 (148.983), paragraph (a), lists the permitted massage and bodywork techniques and the applications that can be used on the client. **Paragraph (b)** lists the prohibited practices. These practices include diagnosing illness or disease; altering a course of recommended therapy issued by a state credentialed health care provider without first consulting the provider; prescribing drugs or medicines; intentionally adjusting or manipulating or mobilizing any articulations of the body or spine applying physical agent modalities; needles that puncture the skin or injection therapy.	Senate only section.	
Section 30 (148.984) requires a massage or bodywork therapist to refer a client to a health care provider if the client’s medical condition is beyond the scope of practice established by this chapter or the rules of the board.	Senate only section.	

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Section 31 (148.985) creates title protection. **Subdivision 1** states that an individual regulated by this chapter is designated as a registered massage and bodywork therapist or "RMBT." **Subdivision 2** prohibits use of "registered massage and bodywork therapist" or "RMBT" or any other words or symbols that indicate a person is a registered massage and bodywork therapist unless the individual is registered under this chapter. **Subdivision 3, paragraph (a)**, specifies that the registered practitioner shall be identified as a "registered massage and bodywork therapist" or "RMBT." **Paragraph (b)** permits the board to adopt rules to implement this section. **Paragraph (c)** permits a practitioner who is credentialed by another state or holds certifications from professional agencies or educational providers to so indicate in advertising. Requires the name of the state and credentialing body to be clearly identified. **Subdivision 4** permits other credentialed practitioners to use massage and bodywork therapy techniques as long as the practitioner does not imply that they are registered under this act.	Senate only section.	

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Section 32 (148.986) requires the board, with the advice of the Advisory Council, to issue registrations to qualified applicants. Lists the powers and duties of the board related to regulation of the profession.	Senate only section.	
Section 33 (148.9861) establishes a registered massage and bodywork therapist advisory council. **Subdivision 1** creates a five-member advisory council with two public members and three registered massage and bodywork therapists. The members are appointed by the board. **Subdivision 2** establishes the process for filling vacancies. **Subdivision 3** requires the council to be organized under certain subdivisions of section 15.059 (Advisory Councils and Committees). **Subdivision 4** requires the council to elect a chair. **Subdivision 5** requires the Board of Nursing to provide meeting space and administrative support to the council. **Subdivision 6** lists the duties of the council. **Subdivision 7** provides that the council does not expire.	Senate only section.	
Section 34 (148.987) establishes registration requirements. **Subdivision 1** requires an applicant to pay the required fees, submit to a criminal background check, and file a	Senate only section.	

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written application. Lists the items that must be included on the application form. **Subdivision 2** permits the board to deny an application for registration if an applicant has been convicted of certain crimes; has been subjected to disciplinary action under Minnesota Statutes, chapter 146A, if the board determines that denial is necessary to protect the public; or the applicant is under investigation for complaints related to the practice of massage and bodywork therapy. **Subdivision 3** lists the requirements for registration by endorsement, including payment of fees, criminal background check, proof of a current and unrestricted massage and bodywork therapy credential in another state, certain information relating to credentials and disciplinary action, and a history of drug or alcohol abuse. States that registration issued by endorsement expires on the same schedule and renewed by same procedures as registrations issued under subdivision 1. **Subdivision 4** lists the requirements for registration by grandfathering. Permits application for registration by this method for two years after the first date the board has made applications for registration available. The applicant must pay the required fees, have a criminal background check, file a written application, provide proof that the applicant is qualified to practice, and provide certain information relating to credentials and		

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disciplinary action and a history of drug or alcohol abuse. Lists acceptable proof. **Subdivision 5** allows the board to issue a temporary permit to an applicant eligible for registration that is valid until the board makes a decision on the application for registration if the application is complete and all applicable fees have been paid.		
Section 35 (148.9871) establishes expiration and renewal requirements. **Subdivision 1** states that registrations expire annually. **Subdivision 2** requires the registrant to complete a renewal application, submit the renewal fee, and submit any other information requested by the board. **Subdivision 3** requires the registrant to inform the board of any change in address within 30 days of the change. **Subdivision 4** requires the board to send a renewal notice to the registrant at least 60 days before the registration renewal date. **Subdivision 5** provides that the renewal application and fee must be postmarked on or before October 1 of the year of renewal, but if the postmark is illegible, then the application is considered timely if it is received by the third working day after the deadline.	Senate only section.	

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Subdivision 6 allows a registrant to place a registration on inactive status and sets the criteria for reactivating the registration. **Subdivision 7** requires an individual to apply for registration renewal if registration has lapsed for two years or less; pay the required fees, including the fee for late renewal; and document compliance with continuing education requirements. **Subdivision 8** prohibits the board from renewing, restoring, or reissuing a registration that has not been renewed within two years. A former registrant must apply and meet the requirements then in existence for initial registration. **Subdivision 9** allows a registrant in good standing to request registration cancelation. If the individual seeks to re-register, the individual must complete a new application and fulfill all requirements then in existence for initial registration.		
Section 36 (148.9881) instructs the board to take action on all applications for registration and determine if an applicant meets the requirements for registration or renewal. Permits the board to investigate the information submitted by the applicant. Requires the board to provide written notification to the applicant on action taken on the application. Provides the process for an applicant to appeal an adverse action.	Senate only section.	

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Section 37 (148.9882) grounds for disciplinary action. **Subdivision 1** provides a list of the grounds for disciplinary action. Disciplinary action may be registration denial, revocation, suspension, limitation, or placing limitations on the registration. **Subdivision 2** provides that judgments or proceedings under seal of the court administrator or administrative agency that entered the judgment are admissible into evidence during a disciplinary proceeding under this section without further authentication and provide prima facie evidence of the violation. **Subdivision 3** authorizes the board to take action if probable cause exists for disciplinary action.	Senate only section.	
Section 38 (148.9883) provides that registered massage and bodywork therapists and applicants are subject to the disciplinary statutes under the board of nursing, sections 148.262 to 148.266.	Senate only section.	
Section 39 (148.9884) describes the effects on municipal ordinances. **Subdivision 1** preempts a municipality from licensing and regulating massage and bodywork therapists, including conducting a criminal background check and examination for a municipality's credential to practice massage and bodywork therapy.	Senate only section.	

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Subdivision 2 states that nothing in sections 148.981 to 148.9885 shall be construed to limit a municipality from: (1) requiring a massage business establishment from obtaining a business license or permit; (2) enforcing health code provisions related to communicable diseases; (3) requiring criminal background checks of unregistered massage and bodywork therapists as part of applying for a license from the municipality; and (4) otherwise regulating massage business establishments by ordinance. **Subdivision 3** gives a municipality the authority to prosecute violations of this act, local ordinances, or other laws.		
Section 40 (148.9885) creates fees. **Subdivision 1** provides a list of fees. **Subdivision 2** requires a late fee if the application for renewal is submitted after the deadline. **Subdivision 3** states that all fees are nonrefundable. **Subdivision 4** requires the board to deposit the fees in the state government special revenue account.	Senate only section.	
Section 41 (153B.10) permits chapter 153B to be cited as the Orthotics, Prosthetics, and Pedorthics Practice Act.	Identical.	**Sec. 22. Short title.** Creates § 153B.10. Provides the title for this act.

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Section 42 (153B.15) defines the following terms: advisory council; board; custom-fabricated device; licensed assistant; licensed orthotic fitter; licensed orthotist; licensed pedorthists; licensed prosthetist; licensed prosthetist orthotist; NCOPE; orthosis; orthotics; over the counter; off the shelf; pedorthic device; pedorthics; prescription; prosthesis; prosthetics; resident; residency; supervisor.	One technical difference. House makes a reference to "this act" and Senate uses "this chapter." Staff recommends Senate.	**Sec. 23. Definitions.** Creates § 153B.15. Defines the following terms: "advisory council," "board," "custom-fabricated device," "licensed orthotic-prosthetic assistant," "licensed orthotic fitter," "licensed orthotist," "licensed pedorthist," "licensed prosthetist," "licensed prosthetist orthotist," "NCOPE," "orthosis," "orthotics," "over-the-counter," "off-the-shelf," "pedorthic device," "pedorthics," "prescription," "prosthesis," "prosthetics," "resident," "residency," and "supervisor."
Section 43 (153B.20) specifies the exceptions to this chapter.	House specifically exempts osteopathic physicians who provide services within the scope of their practice from the requirements of this chapter. Senate does not specifically exempt osteopathic physicians. Staff recommends House. Senate specifically exempts chiropractors who provide services within the scope of their practice from the requirements of this chapter. House does not specifically exempt chiropractors. Staff recommends Senate.	**Sec. 24. Exceptions.** Creates § 153B.20. Exempts the following from the provisions of this act: • licensed physicians, osteopathic physicians, or podiatric physicians who are providing service within the scope of their practice; • professionals, such as physical therapists and occupational therapists, who are providing services within the scope of their practice; • individuals who practice orthotics, prosthetics, or pedorthics as part of their employment by the federal government or federal agency; • orthotic, prosthetic, or pedorthic students, residents, and interns; or an orthotist, prosthetist, pedorthist, prosthetic orthotist, assistant, or fitter who is licensed in another state or another country that has equivalent licensure requirements, and has applied for licensure under this act.

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Section 44 (153B.25) establishes an advisory council.	Identical.	**Sec. 25. Orthotics, Prosthetics, and Pedorthics Advisory Council.** Creates § 153B.25. Establishes a seven member advisory council.
Section 45 (153B.30) establishes licensure requirements. **Subdivision 1** requires the licensure application to be submitted to the Board of Podiatric Medicine. **Subdivision 2** establishes licensure requirements for each of the following: orthotist, prosthetist, prosthetist orthotist, a pedorthist, an orthotic or prosthetic assistant, and an orthotic fitter. **Subdivision 3** states that the term of a license is for two years beginning on January 1 or beginning after initially fulfilling the license requirements and ending on December 31 of the following year.	Identical.	**Sec. 26. Licensure.** Creates § 153B.30. **Subd. 1. Application.** Requires applicants to submit a license application in the format required by the board, accompanied by the required nonrefundable fee. **Subd. 2. Qualifications.** Requires applicants to meet the certification requirements of applicable national certifying board at the time of application and to be in good standing with the certifying board. **Subd. 3. License term.** Provides that a license is valid for a term of up to 24 months beginning on January 1, or commencing after fulfilling the license requirements and ending on December 31 of the following year.
Section 46 (153B.35) permits a licensed orthotist, pedorthist, assistant, or orthotic fitter to provide limited supervised patient care services beyond their scope of practice if (1) the licensee is employed by a patient care facility that is accredited by a national accrediting organization; (2) written objective criteria are documented by the facility that describes the knowledge and skill required by the licensee to demonstrate competency; and (3) the licensee provides patient care only at the direction of a supervisor who is licensed and employed by the facility;	Senate specifies "orthotic or prosthetic patient care services." House refers to "patient care services." Staff recommends Senate.	**Sec. 27. Employment by an accredited facility; scope of practice.** Creates § 153B.35. Allows a licensee to provide limited, supervised patient care beyond their scope of practice if: • the licensee is employed by a facility that is accredited by a national accrediting organization in orthotics, prosthetics, and pedorthics; • written objective criteria are provided by the facility to describe the knowledge and skills required by the

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and (4) the supervised patient care occurs in compliance with facility accreditation standards.		licensee to demonstrate competence to provide services outside the licensee's scope of practice; • the licensee is under the direction of supervisor licensed as an orthotist, prosthetist, or pedorthist who is employed by the facility; and the patient care occurs in compliance with facility accreditation standards.
Section 47 (153B.40) establishes the continuing education requirements.	Identical.	**Sec. 28. Continuing education.** Creates § 153B.40. **Subd. 1. Requirement.** Requires each licensee to comply with the continuing education requirements imposed by their certifying board. **Subd. 2. Proof of attendance.** Requires each licensee to submit to the board proof of attendance at approved continuing education programs during the licensure period. **Subd. 3. Extension of continuing education requirements.** Allows a licensee, for good cause, to apply for a six-month extension in order to complete continuing education requirements. Allows up to two consecutive extensions. "Good cause" is defined as unforeseen hardship.
Section 48 (153B.45) establishes licensure renewal requirements.	Identical.	**Sec. 29. License renewal.** Creates § 153B.45. **Subd. 1. Submission of license renewal form.** Requires a licensee to submit a signed renewal application to the board that is postmarked no later than January 1.

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		Subd. 2. Renewal application postmarked after January 1. Requires the applicant to pay a late renewal fee if the application is postmarked after January 1. **Subd. 3. Failure to submit renewal application.** Paragraph (a) requires the board to mail a notice to a licensee who fails to apply for license renewal. Provides that the notice must contain information on the steps that must be taken by the licensee to renew the license or to voluntarily terminate the license. Paragraph (b) provides that a licensee's failure to respond to the notice shall result in expiration of the license and termination of the right to practice. Paragraph (c) provides that an expired license may be reinstated.
Section 49 (153B.50) requires a licensee to inform the board of a name or address change.	Identical.	**Sec. 30. Name and address change.** Creates § 153B.50. Paragraph (a) instructs a licensee to notify the board of any name change within 90 days of the change. Paragraph (b) requires a licensee to maintain a correct address with the board. Instructs a licensee to notify the board of any address change within 90 days of the change.

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Section 50 (153B.55) permits a licensee to put the license on inactive status.	Identical.	**Sec. 31. Inactive status.** Creates § 153B.55. Paragraph (a) allows a licensee to place the licensee's credential on active status. Paragraph (b) requires a licensee who requests restoration of a credential to complete a license renewal application and pay the current renewal fee. Paragraph (c) provides that a person whose license is on inactive status cannot practice.
Section 51 (153B.60) permits a licensee whose license has expired while on active military duty or while in training or education preliminary to induction in the military to have the license renewed or restored without paying a late fee or license restoration fee.	Identical.	**Sec. 32. License lapse due to military service.** Creates § 153B.60. Allows service members whose license expire while on active duty or while in training or education prior to induction, to have their license renewed or restored without paying a late fee or a restoration fee.
Section 52 (153B.65) authorizes the board to license without examination and on payment of the required fee an applicant who is certified from an organization with educational, experiential, and testing standards that are equal to or higher than the licensing requirements in Minnesota.	Identical.	**Sec. 33. Endorsement.** Creates § 153B.65. Allows the board to issue a license, without examination, to applicants who are certified by a national certification organization.
Section 53 (153B.70) establishes grounds for disciplinary action.	Technical difference. Staff recommends Senate.	**Sec. 34. Grounds for disciplinary action.** Creates § 153B.70. Lists the grounds for adverse action by the board against an applicant or licensee.

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Section 54 (153B.75) authorizes the board to investigate alleged violations, conduct hearings, and impose corrective or disciplinary action.	Identical.	**Sec. 35. Investigation; notice and hearings.** Creates § 153B.75. Authorizes the board to investigate alleged violations of the practice act, conduct hearings, and impose corrective or disciplinary action as provided in section 214.103 (Health-related licensing boards; complaint, investigation, and hearing.)
Section 55 (153B.80) Effective January 1, 2018**,** a person is prohibited from practicing or representing oneself as an orthotist, prosthetist, prosthetist orthotist, pedorthist, assistant, or fitter without a license and is guilty of a misdemeanor. Gives the board authority to seek a cease and desist order against any person engaged in unlicensed practice.	Identical.	**Sec. 36. Unlicensed practice.** Creates § 153B.80. • Requires individuals to hold a license in order to practice one of the professions regulated by this act; and • Prohibits any individual from holding oneself out as a professional regulated by this act if the person is not regulated; and makes it a misdemeanor for a person to practice or hold oneself out as an orthotist, prosthetist, prosthetist orthotist, pedorthist, assistant, or fitter without a license. Grants the board the authority to seek a cease and desist order.
Section 56 (153B.85) establishes fees.	Structural differences. Senate divides the section into subdivisions. Staff recommends Senate.	**Sec. 37. Fees.** Creates § 153B.85. Lists various application and renewal fees.
Section 57 (214.075, subd. 3) specifies that the fees received by the health-related licensing boards for the criminal background checks are to be deposited in dedicated accounts in the special revenue fund and are appropriated to the health-related licensing boards.	Senate only section.	

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Section 58 (256B.0625, subd. 18a) specifies that beginning July 1, 2018, spoken language health care interpreter services must be provided by an interpreter who is listed on the registry for the services to be covered by medical assistance. Prior to July 1, 2018, the interpreter must either be listed on the current roster or listed in the new registry.	Identical, technical differences. Staff recommends Senate.	**Sec. 17. Access to medical services.** Amends Minnesota Statutes 2015 Supplement, § 256B.0625, subd. 18a. Makes technical changes to conform to changes made by this bill. Provides that medical assistance shall cover only spoken language health care interpreter services provided by an interpreter listed on the registry. Provides an effective date of July 1, 2017.
Section 59 (325F.816) prohibits an individual who has a business license from a municipality to practice massage from advertising as a licensed massage therapist unless the individual has a valid professional credential from another state, is current in licensure, and is in good standing with the other state.	Senate only section.	
Section 60 requires the Board of Pediatric Medicine to make its first appointments to the Orthotics, Prosthetics, and Pedorthics Advisory Council by September 1, 2016.	Identical.	**Sec. 38. First appointments, first meeting, and first chair of the Orthotics, Prosthetics, and Pedorthics Advisory Council.** Instructs the board to make appointments to the council by September 1, 2016. Requires the council to convene by November 1, 2016.
Section 61 sets deadlines for initial appointments and convening the first meeting of the Registered Massage and Bodywork Therapist Advisory Council. Sets terms for the initial appointees to the council.	Senate only section.	

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Section 62 requires the Commissioner of Health to work with community stakeholders to study and identify barriers, challenges, and successes affecting initiation, duration, and exclusivity of breastfeeding. The study must address policy, systemic, and environmental factors that both support and create barriers to breastfeeding. The study must identify and make recommendations regarding culturally appropriate practices that have been shown to increase breastfeeding rates in populations that have the greatest breastfeeding disparities.	Senate only section.	
Section 63 requires the Commissioner of Health to convene the first meeting of the Spoken Language Health Care Advisory Council by October 1, 2016.	Identical.	**Sec. 19. Initial spoken language health care advisory council meeting.** Requires the commissioner to convene the first council meeting by October 1, 2016.
Section 64 specifies that the initial fees for interpreters listed on the Spoken Language Health Care Registry for the first year shall be $50 and for the second year shall be $70. After the second year, the fees shall be $90.	Identical.	**Sec. 20. Spoken language health care interpreter registry fees.** Provides that the initial and renewal fees for registrants shall be $50 between July 1, 2017, and June 30, 2018. Between July 1, 2018, and June 30, 2019, the fees shall be $70. Beginning July 1, 2019, the fees shall be in accordance with section 148.9987.
Section 65 requires the Commissioner of Human Services, in consultation with the Commissioner of Health, the advisory council and interested community stakeholders to study and make recommendations for creating a tiered reimbursement system for the public health care programs for spoken language health care interpreters based on the different tiers of the spoken language health care interpreters registry. Requires the commissioner to submit the proposed reimbursement system including the fiscal costs for the proposed system to the legislature by January 15. 2017. Requires the commissioner of	Identical.	**Sec. 18. Stratified medical assistance reimbursement system for spoken language health care interpreters.** Paragraph (a) instructs the commissioner of human services, in consultation with the commissioner of health, the advisory council, and stakeholders from the interpreting community to study and make recommendations for a reimbursement system based on the different tiers of the registry. Paragraph (b) requires the commissioner of human services to submit the proposed reimbursement system, including a fiscal

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health to review the fees and make recommendations on whether the fees are at the appropriate levels and whether the fees should be different for each tier of the registry.		note, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services by January 15, 2018.
Section 66 repeals section 144.058 (current spoken language health care interpreter roster system) effective July 1. 2018.	Identical.	**Sec. 21. Repealer.** Repeals § 144.058 (Interpreter services quality initiative.) effective July 1, 2017.