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S.F. No. XXXX – HHS Supplemental Budget Articles

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Article 1 – Children and Families

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 seven percent.

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. (Section 23)

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 256K and related federal law.

Section 4 (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.

Section 5 (256N.26, subd. 3) increases the basic monthly rate for Northstar Care for Children by 15 percent.

Section 6 (256P.06, subd. 3) clarifies that income includes all child support that the assistance unit receives, not just current support.

Section 7 (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.

Section 8 (260C.203) strikes language that is consolidated in a new section of law, section 260C.452.

Section 9 (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.

Section 10 (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.

Section 11 (260C.215, subd. 4) requires the curriculum for foster parents to include, as necessary, knowledge and skills related to reasonable and prudent parenting standards.

Section 12 (260C.451, subd. 6) clarifies that a child may reenter foster care prior to 21 years of age.

Section 13 (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.

Section 14 (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.

Section 15 (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.

Section 16 (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.

Section 17 (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.

Section 18 (518A.26, subd. 14) amends the definition of "obligor" to provide that if a parent has more than 55% 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.

Section 19 (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.

Section 20 (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.

Section 21 (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.
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> **Subdivision 2** contains the new formula for the calculation of the parenting expense adjustment.
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> **Subdivision 3** strikes language applicable in cases where parenting time is equal, which is replaced by new provisions in **subdivision 2**.

Section 22 (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.

Section 23 (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.

Section 24 (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.

Section 25 (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.

Section 26 (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.

Section 27 (626.556, subd. 10b) requires the Commissioner of Human Services to investigate every incident involving the death of a child during placement in a licensed child foster care home.

Section 28 (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.

Section 29 requires that allowable child protection services be expanded to include child care.

Section 30 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.

Section 31 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.

Article 2 – 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.

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.

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.

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. This section is effective the day following final enactment.

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.

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).

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.

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.

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.

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.

Section 12 (256B.0625, subd. 20) modifies the mental health targeted case management section of law to allow medical assistance reimbursement for contact by interactive video.

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.

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.

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.

Section 16 requires the Commissioner of Human Services to seek federal approval for interactive video contact.

Article 3 – Direct Care and Treatment

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.

Section 2 (246.50, subd. 7) clarifies the definition related to the county of financial responsibility for state-operated services.

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, 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.

Section 4 (246B.01, subd. 1b) clarifies the definition related to the county of financial responsibility for the Minnesota Sex Offender Program.

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.

Section 6 (**246B.035)** requires the annual MSOP performance report by February 15 beginning in 2017.

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.

Article 4 - Continuing Care

Section 1 (245A.10, subd. 4, paragraph (b), clause (1)) 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 provision of 245D licensed services. The commissioner must calculate a provider's fee based on paid claims invoiced by that provider.

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.

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.

Section 4 (256B.0949) adds new language concerning an existing benefit for the treatment of children with autism spectrum disorders and related conditions.

> **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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> **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.

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.

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 and the use of the qualification exception process. The commissioner may not terminate the exemption authority without providing 30 days' notice for public comment.

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.

Section 6 (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.

Section 7 (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.

Section 8 (256B.4914, subd. 10) replaces "county" and "county and tribal" with "Lead agency".

Section 9 (256B.4914, subd. 11) replaces "county" with "lead agency".

Section 10 (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.

Section 11 (256B.4914, subd. 15) replaces "county and tribal" and "county" with "lead agency".

Section 12 (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.

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.

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.

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 13 (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.

Section 14 (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.

Article 5 - Health Care

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.

Sections 2 to 20 and section 28 cover the changes in prior authorization and utilization review for prescription drugs.

Section 2 (62J.497, subd. 1) adds a definition of utilization review organization.

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.

Section 4 (62M.02, subd. 10a) adds a definition for "drug."

Section 5 (62M.02, subd. 11a) adds a definition for "formulary."

Section 6 (62M.02, subd. 12) modifies the definition of health benefit plan to include a health plan that provides coverage of prescription drugs.

Section 7 (62M.02, subd. 14) modifies the definition of "outpatient services" to include prescription drugs.

Section 8 (62M.02, subd. 14b) adds a definition for "prescription."

Section 9 (62M.02, subd. 14c) adds a definition for "prescription drug order."

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.

Section 11 (62M.02, subd. 17) modifies the definition of "provider" to include a licensed pharmacist.

Section 12 (62M.02, subd. 18a) adds a definition for "quantity limit."

Section 13 (62M.02, subd. 19a) adds a definition for "step therapy."

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.

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.

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.

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.

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 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.

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.

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.

Section 22 (62Q.83) creates prescription drug benefit transparency and management requirements.

Subd. 1 defines the following terms: drug; enrollee contract year; formulary; health plan company; and prescription.

Subd. 2 requires a health plan company that cover prescription drugs and uses a formulary to make its formulary and related benefit information available by electronic means and, upon request, in writing at least 30 days prior to annual renewal dates.

Subd. 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.

Subd. 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.

Subd. 5. Paragraph (a) requires each health plan company to establish and maintain a medical exceptions process that allows enrollees, providers, and an authorized representative to request and obtain coverage approval in certain situations.

Paragraph (b) requires the exception 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.

Paragraph (c) requires the medical exceptions process to comply with the requirements under chapter 62M (utilization review).

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 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.

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).

Section 25 (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.

Section 26 (256B.057, subd. 12a) 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.

Sections 27 to 31 concern compliance with federal antispousal impoverishment requirements.

Section 27 (256B.059, subd. 1) strikes the definition of "spousal share" and thereby removes 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.

Section 28 (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.

Section 29 (256B.059, subd. 3) sets the maximum value of assets a community spouse may retain to $119,220. The maximum 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.

Section 30 (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.

Section 31 (256B.059, subd. 7) expands the definition of "institutionalized spouse" to include (1) effective June 1, 2016, a spouse applying after June 1, 2016, for disability waiver services (2) effective March 1, 2017, a spouse enrolled prior to June 1, 2016, to receive waiver services and (3) effective June 1, 2016, a spouse applying for community first services and supports.

Section 32 (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.

Section 33 (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.

Section 34 (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.

Section 35 (256B.0625, subd. 30) requires the commissioner to seek a section 1115 federal waiver in order to obtain enhanced federal financial participation payment for organizations that are dually

certified under the Indian Health Care Improvement Act and a federally qualified health center and provide services to eligible American Indians and Alaskan Natives.

Section 36 (256B.0625, subd. 31) specifies that the allergen products described in section 256B.0625, subdivision 65, shall be considered durable medical equipment.

Section 37 (256B.0625, subd 58) increases the payment rate for EPSDT screenings by five percent.

Section 38 (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;
- 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.

Section 39 (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;
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.

Sections 40 to 42 retroactively limits medical assistance estate recoveries for those individuals 55 years of age or older who receive medical assistance while not institutionalized.

Section 40 (256B.15, subd. 1) makes a conforming change to the estate recovery language by striking a reference to "total" cost of medical assistance an individual receives.

Section 41 (256B.15, subd. 1, 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) resided in an institution for six months or longer at any age.

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) resided in an institution for six months or longer at any age.

Section 42 (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, or 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.

Section 43 (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.

Section 44 (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.

Section 45 (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 above the rates in effect on June 30, 2015. 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.

Section 46 (256B.76, subd. 4) Paragraph (a) modifies the medical assistance critical access dental payments from 35 percent to 37 percent.

Paragraph (b) modifies the calculation used to determine the critical access dental payments.

Paragraph (c) 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.

Section 47 (256B.761) increases payment rates for outpatient mental health services by five percent.

Section 48 (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.

Section 49 (256B.766) clarifies the medical assistance rate increase that was passed last year for durable medical equipment and supplies.

Sections 50 to 63 and 66, paragraph (b), make changes to the MinnesotaCare program to comply with federal regulations and expands the income eligibility for the program to 275 percent of the federal poverty guidelines if federal approval is granted or January 1, 2018, whichever is later.

Section 50 (256L.01, subd.1a) modifies the definition of child to an individual under the age of 21.

Section 51 (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.

Section 52 (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.

Section 53 (256L.04, subd. 1) increases the income eligibility limit for MinnesotaCare from 200 percent to 275 percent for families with children.

Section 54 (256L.04, subd.1a) requires individual and families applying to MinnesotaCare to provide a Social Security number if required under the federal regulations.

Section 55 (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.

Section 56 (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.

Section 57 (256L.04, subd.7b) requires the commissioner to adjust the income limits annually each July 1 instead of January 1.

Section 58 (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.

Section 59 (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.

Section 60 (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.

Section 61 (26L.11, subd. 7) increases the critical access dental payments for MinnesotaCare from 30 percent to 32 percent.

Section 62 (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.

Section 63 (256L.15, subd. 2) requires the commissioner to extend the premium scale for MinnesotaCare to include individuals with incomes greater than 200 percent, but not exceeding 275 percent of FPG so that the individuals with income at 201 percent of FPG shall pay 4.09 percent of income, individuals with income at 251 percent of FPG shall pay 7.26 percent of income, and individuals with income at 275 percent of FPG shall pay 8.83 percent of income. Requires the commissioner to set other premium amounts in a proportional manner using evenly spaced income steps.

Section 64 (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; and replace the annual open enrollment period with an alternative.

Section 65 (Direction to the Commissioner; Notice) requires the Department of Human Services within 90 days of enactment to notify anyone who received medical assistance nonlong-term care services of the amendments to the estate recovery language in this bill.

Section 66 (Repealer.) Paragraph (a), repeals obsolete language concerning the implementation of the rules governing the treatment of marital assets when a spouse is institutionalized. **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.

Article 6 – Health Departments

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.

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.

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.

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.

Section 5 (62D.115) establishes an investigation process for quality of care complaints for HMOs.

Subd. 1 defines quality of care complaints.

Subd. 2 requires each HMO to develop and implement policies and procedures for the receipt, investigation, and resolution of quality of care complaints.

Subd. 3, paragraph (a), requires HMOs to report quality of complaints as part of their annual report required under section 62D.08.

Paragraph (b) requires quality of care complaints received by the HMO that meet the highest level of severity as defined by the commissioner must be reported to the commissioner within ten calendar days of receipt of the complaint. Requires the commissioner to investigate the complaint and authorizes the commissioner to contract with experts in health care or medical practice to assist in the investigation. Requires the commissioner to provide to the person who made the complaint a written description of the commissioner's investigative process and any action taken by the commissioner relating to the complaint. Specifies that if the commissioner takes any corrective action or requires the HMO to make any corrective measures of any kind that the nature of the complaint and the action or measures taken are public data.

Paragraph (c) requires the commissioner to forward any quality of care complaints received by a HMO or received directly from an enrollee of a HMO that involves services by a health care provider or facility to the relevant health-related licensing board or state agency, for further investigation, upon the consent of the enrollee.

Subd. 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.

Subd. 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.

Subd. 6 describes the external quality of care review process.

Subd. 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

Subd. 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; and (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.

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.

Section 8 (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.

Section 9 (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.

Section 10 (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.

Section 11 (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.

Section 12 (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.

Section 13 (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.

Section 14 (144.4961, subd. 8) modifies the fees for radon licenses.

Section 15 (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.

Section 16 (144A.75, subdivision 5) removes from the definition of "hospice provider" the condition that a hospice patient must be terminally ill.

Section 17 (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.

Section 18 (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."

Section 19 (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.

Section 20 (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."

Section 21 (152.27, subd. 2) permits health care practitioners who meet the definition of a health care practitioner in the medical cannabis registry program and who request access for a permissible purpose to have limited access to a patient's registry information.

Section 22 (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 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 23 (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.

Section 24 (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.

Section 25 amends the effective date for licensure of radon control systems.

Section 26 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.

Section 27 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.

Section 28 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 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.

Section 29 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.

Section 30 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 up to 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. Requires the commissioner to report the results to the legislature by October 1, 2017.

Article 7 – Health-Related Licensing Boards

Sections 1 to 7 create a registry for spoken language health care interpreters.

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.

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.
>
> **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.
>
> **Subd. 2** describes the requirements for the tier 1 registry.
>
> **Subd. 3** describes the requirements for the tier 2 registry.

Subd. 4 describes the requirements for the tier 3 registry.

Subd. 5 describes the requirements for the tier 4 registry.

Subd. 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.

Subd. 7 specifies that all information submitted to the commissioner by an applicant is classified in accordance with section 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.

Subd. 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 must be received by the commissioner or postmarked at least 30 days before the expiration date.

Subd. 3 requires the renewal application to include the late fee if submitted after the deadline.

Subd. 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.

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.

Subd. 2 authorizes the commissioner to initiate an investigation upon receiving a complaint alleging a violation.

Subd. 3 lists the disciplinary action the commissioner may take.

Subd. 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.

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.

Subd. 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.

Section 6 (146C.11) establishes the spoken language health care interpreter advisory council. Describes the makeup of the council and their duties.

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.

Sections 8 to 16 create licensure for genetic counselors.

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.

Section 9 (147F.03) describes the scope of practice for the practice of genetic counseling by a licensed genetic counselor.

Section 10 (147F.05) prohibits unlicensed practice and establishes title protection.

Subd. 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.

Subd. 2 prohibits an individual from practicing genetic counseling unless the individual is licensed as a genetic counselor under this chapter, effective January 1, 2018.

Subd. 3, paragraph (a) specifies that nothing in this chapter prohibits an individual who is duly licensed 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.

Subd. 4 states that any individual who violates this section is guilty of a misdemeanor and is subject to sanctions under section 214.11.

Section 11 (147F.07) requirements for licensure.

Subd. 1 establishes the general requirements for licensure.

Subd. 2 establishes the requirements for licensure by reciprocity.

Subd. 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 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.

Subd. 4 states that a license is valid for one year from the date of issuance.

Subd. 5 establishes the requirements for license renewal.

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 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.

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)

Section 15 (147F.15) establishes the Licensed Genetic Counselor Advisory Council.

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.

Sections 17 to 27 create licensure for lactation care providers.

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.

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.

Section 19 (148.9803) prohibits unlicensed practice and restricts the use of protected titles.

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.

Subd. 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.

Subd. 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, 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.

Subd. 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.

Subd. 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.

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 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.

Subd. 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.

Subd. 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 licensure based on disciplinary grounds. Requires the applicants to provide verification of the credentials to the commissioner.

Subd. 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.

Subd. 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.

Subd. 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.

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.

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.

Section 26 (148.9811) establishes the various licensure fees, including duplicate license fees, late fees, and penalty fees.

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.

Subd. 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.

Subd. 3 lists the types of disciplinary action that may be taken by the commissioner.

Subd. 4 requires the licensee to cease using the protected title if disciplinary action imposed prevents the individual from providing clinical lactation services.

Subd. 5 permits an individual whose license has been suspended to request reinstatement.

Subd. 6 requires the commissioner to contract with the health professional services program to provide services to licensees.

Sections 28 to 40 create registration for massage and bodywork therapists.

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."

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.

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.

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.

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.

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.

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 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 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.

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.

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.

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.

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.

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.

Sections 41 to 56 create licensure for orthodics, pedorthics, and prosthetics.

Section 41 (153B.10) permits chapter 153B to be cited as the Orthotics, Prosthetics, and Pedorthics Practice Act.

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.

Section 43 (153B.20) specifies the exceptions to this chapter.

Section 44 (153B.25) establishes an 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.

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; and (4) the supervised patient care occurs in compliance with facility accreditation standards.

Section 47 (153B.40) establishes the continuing education requirements.

Section 48 (153B.45) establishes licensure renewal requirements.

Section 49 (153B.50) requires a licensee to inform the board of a name or address change.

Section 50 (153B.55) permits a licensee to put the license on inactive status.

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.

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.

Section 53 (153B.70) establishes grounds for disciplinary action.

Section 54 (153B.75) authorizes the board to investigate alleged violations, conduct hearings, and impose corrective or disciplinary action.

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.

Section 56 (153B.85) establishes 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.

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.

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.

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.

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.

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.

Section 63 requires the Commissioner of Health to convene the first meeting of the Spoken Language Health Care Advisory Council 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.

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 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.

Section 66 repeals section 144.058 (current spoken language health care interpreter roster system) effective July 1. 2018.