

124.1

**ARTICLE 6**

124.2

**DEPARTMENT OF HEALTH POLICY**

124.3 Section 1. Minnesota Statutes 2022, section 62D.14, subdivision 1, is amended to read:

124.4 Subdivision 1. **Examination authority.** The commissioner of health may make an  
124.5 examination of the affairs of any health maintenance organization and its contracts,  
124.6 agreements, or other arrangements with any participating entity as often as the commissioner  
124.7 of health deems necessary for the protection of the interests of the people of this state, but  
124.8 not less frequently than once every ~~three~~ five years. Examinations of participating entities  
124.9 pursuant to this subdivision shall be limited to their dealings with the health maintenance  
124.10 organization and its enrollees, except that examinations of major participating entities may  
124.11 include inspection of the entity's financial statements kept in the ordinary course of business.  
124.12 The commissioner may require major participating entities to submit the financial statements  
124.13 directly to the commissioner. Financial statements of major participating entities are subject  
124.14 to the provisions of section 13.37, subdivision 1, clause (b), upon request of the major  
124.15 participating entity or the health maintenance organization with which it contracts.

124.16 Sec. 2. **[62J.461] 340B COVERED ENTITY REPORT.**

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

124.19 (b) "340B covered entity" or "covered entity" means a covered entity as defined in United  
124.20 States Code, title 42, section 256b(a)(4), with a service address in Minnesota as of January  
124.21 1 of the reporting year. 340B covered entity includes all entity types and grantees. All  
124.22 facilities that are identified as child sites or grantee associated sites under the federal 340B  
124.23 Drug Pricing Program are considered part of the 340B covered entity.

124.24 (c) "340B Drug Pricing Program" or "340B program" means the drug discount program  
124.25 established under United States Code, title 42, section 256b.

124.26 (d) "340B entity type" is the designation of the 340B covered entity according to the  
124.27 entity types specified in United States Code, title 42, section 256b(a)(4).

124.28 (e) "340B ID" is the unique identification number provided by the Health Resources  
124.29 and Services Administration to identify a 340B-eligible entity in the 340B Office of Pharmacy  
124.30 Affairs Information System.

124.31 (f) "Contract pharmacy" means a pharmacy with which a 340B covered entity has an  
124.32 arrangement to dispense drugs purchased under the 340B Drug Pricing Program.

125.1 (g) "Pricing unit" means the smallest dispensable amount of a prescription drug product  
125.2 that can be dispensed or administered.

144.14

**ARTICLE 6**

144.15

**DEPARTMENT OF HEALTH POLICY**

106.20 Section 1. Minnesota Statutes 2022, section 62D.14, subdivision 1, is amended to read:

106.21 Subdivision 1. **Examination authority.** The commissioner of health may make an  
106.22 examination of the affairs of any health maintenance organization and its contracts,  
106.23 agreements, or other arrangements with any participating entity as often as the commissioner  
106.24 of health deems necessary for the protection of the interests of the people of this state, but  
106.25 not less frequently than once every ~~three~~ five years. Examinations of participating entities  
106.26 pursuant to this subdivision shall be limited to their dealings with the health maintenance  
106.27 organization and its enrollees, except that examinations of major participating entities may  
106.28 include inspection of the entity's financial statements kept in the ordinary course of business.  
106.29 The commissioner may require major participating entities to submit the financial statements  
106.30 directly to the commissioner. Financial statements of major participating entities are subject  
107.1 to the provisions of section 13.37, subdivision 1, clause (b), upon request of the major  
107.2 participating entity or the health maintenance organization with which it contracts.

144.16 Section 1. **[62J.461] 340B COVERED ENTITY REPORT.**

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

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144.21 1 of the reporting year. 340B covered entity includes all entity types and grantees. All  
144.22 facilities that are identified as child sites or grantee associated sites under the federal 340B  
144.23 Drug Pricing Program are considered part of the 340B covered entity.

144.24 (c) "340B Drug Pricing Program" or "340B program" means the drug discount program  
144.25 established under United States Code, title 42, section 256b.

144.26 (d) "340B entity type" is the designation of the 340B covered entity according to the  
144.27 entity types specified in United States Code, title 42, section 256b(a)(4).

144.28 (e) "340B ID" is the unique identification number provided by the Health Resources  
144.29 and Services Administration to identify a 340B-eligible entity in the 340B Office of Pharmacy  
144.30 Affairs Information System.

145.1 (f) "Contract pharmacy" means a pharmacy with which a 340B covered entity has an  
145.2 arrangement to dispense drugs purchased under the 340B Drug Pricing Program.

145.3 (g) "Pricing unit" means the smallest dispensable amount of a prescription drug product  
145.4 that can be dispensed or administered.

125.3 Subd. 2. **Current registration.** Beginning April 1, 2024, each 340B covered entity must  
125.4 maintain a current registration with the commissioner in a form and manner prescribed by  
125.5 the commissioner. The registration must include the following information:

- 125.6 (1) the name of the 340B covered entity;  
125.7 (2) the 340B ID of the 340B covered entity;  
125.8 (3) the servicing address of the 340B covered entity; and  
125.9 (4) the 340B entity type of the 340B covered entity.

125.10 Subd. 3. **Reporting by covered entities to the commissioner.** (a) Each 340B covered  
125.11 entity shall report to the commissioner by April 1, 2024, and by April 1 of each year  
125.12 thereafter, the following information for transactions conducted by the 340B covered entity  
125.13 or on its behalf, and related to its participation in the federal 340B program for the previous  
125.14 calendar year:

- 125.15 (1) the aggregated acquisition cost for prescription drugs obtained under the 340B  
125.16 program;  
125.17 (2) the aggregated payment amount received for drugs obtained under the 340B program  
125.18 and dispensed or administered to patients;  
125.19 (3) the number of pricing units dispensed or administered for prescription drugs described  
125.20 in clause (2); and  
125.21 (4) the aggregated payments made:  
125.22 (i) to contract pharmacies to dispense drugs obtained under the 340B program;  
125.23 (ii) to any other entity that is not the covered entity and is not a contract pharmacy for  
125.24 managing any aspect of the covered entity's 340B program; and  
125.25 (iii) for all other expenses related to administering the 340B program.

125.26 The information under clauses (2) and (3) must be reported by payer type, including but  
125.27 not limited to commercial insurance, medical assistance, MinnesotaCare, and Medicare, in  
125.28 the form and manner prescribed by the commissioner.

125.29 (b) For covered entities that are hospitals, the information required under paragraph (a),  
125.30 clauses (1) to (3), must also be reported at the national drug code level for the 50 most  
125.31 frequently dispensed or administered drugs by the facility under the 340B program.

126.1 (c) Data submitted to the commissioner under paragraphs (a) and (b) are classified as  
126.2 nonpublic data, as defined in section 13.02, subdivision 9.

126.3 Subd. 4. **Enforcement and exceptions.** (a) Any health care entity subject to reporting  
126.4 under this section that fails to provide data in the form and manner prescribed by the  
126.5 commissioner is subject to a fine paid to the commissioner of up to \$500 for each day the

145.5 Subd. 2. **Current registration.** Beginning April 1, 2024, each 340B covered entity must  
145.6 maintain a current registration with the commissioner in a form and manner prescribed by  
145.7 the commissioner. The registration must include the following information:

- 145.8 (1) the name of the 340B covered entity;  
145.9 (2) the 340B ID of the 340B covered entity;  
145.10 (3) the servicing address of the 340B covered entity; and  
145.11 (4) the 340B entity type of the 340B covered entity.

145.12 Subd. 3. **Reporting by covered entities to the commissioner.** (a) Each 340B covered  
145.13 entity shall report to the commissioner by April 1, 2024, and by April 1 of each year  
145.14 thereafter, the following information for transactions conducted by the 340B covered entity  
145.15 or on its behalf, and related to its participation in the federal 340B program for the previous  
145.16 calendar year:

- 145.17 (1) the aggregated acquisition cost for prescription drugs obtained under the 340B  
145.18 program;  
145.19 (2) the aggregated payment amount received for drugs obtained under the 340B program  
145.20 and dispensed or administered to patients;  
145.21 (3) the number of pricing units dispensed or administered for prescription drugs described  
145.22 in clause (2); and  
145.23 (4) the aggregated payments made:  
145.24 (i) to contract pharmacies to dispense drugs obtained under the 340B program;  
145.25 (ii) to any other entity that is not the covered entity and is not a contract pharmacy for  
145.26 managing any aspect of the covered entity's 340B program; and  
145.27 (iii) for all other expenses related to administering the 340B program.

145.28 The information under clauses (2) and (3) must be reported by payer type, including but  
145.29 not limited to commercial insurance, medical assistance, MinnesotaCare, and Medicare, in  
145.30 the form and manner prescribed by the commissioner.

146.1 (b) For covered entities that are hospitals, the information required under paragraph (a),  
146.2 clauses (1) to (3), must also be reported at the national drug code level for the 50 most  
146.3 frequently dispensed or administered drugs by the facility under the 340B program.

146.4 (c) Data submitted to the commissioner under paragraphs (a) and (b) are classified as  
146.5 nonpublic data, as defined in section 13.02, subdivision 9.

146.6 Subd. 4. **Enforcement and exceptions.** (a) Any health care entity subject to reporting  
146.7 under this section that fails to provide data in the form and manner prescribed by the  
146.8 commissioner is subject to a fine paid to the commissioner of up to \$500 for each day the

126.6 data are past due. Any fine levied against the entity under this subdivision is subject to the  
126.7 contested case and judicial review provisions of sections 14.57 and 14.69.

126.8 (b) The commissioner may grant an entity an extension of or exemption from the reporting  
126.9 obligations under this subdivision, upon a showing of good cause by the entity.

126.10 Subd. 5. **Reports to the legislature.** By November 15, 2024, and by November 15 of  
126.11 each year thereafter, the commissioner shall submit to the chairs and ranking minority  
126.12 members of the legislative committees with jurisdiction over health care finance and policy,  
126.13 a report that aggregates the data submitted under subdivision 3, paragraphs (a) and (b). The  
126.14 data shall be aggregated in a manner that prevents the identification of an individual entity  
126.15 and any entity's specific data value reported for an individual data element, except that the  
126.16 following shall be included in the report:

126.17 (1) the information submitted under subdivision 2; and

126.18 (2) for each 340B entity identified in subdivision 2, that entity's 340B net revenue as  
126.19 calculated using the data submitted under subdivision 3, paragraph (a), with net revenue  
126.20 being subdivision 3, paragraph (a), clause (2), less the sum of subdivision 3, paragraph (a),  
126.21 clauses (1) and (4).

126.22 Sec. 3. Minnesota Statutes 2022, section 62J.61, subdivision 5, is amended to read:

126.23 Subd. 5. ~~Biennial review of rulemaking procedures and rules~~ **Opportunity for**  
126.24 **comment.** The commissioner shall biennially seek comments from affected parties maintain  
126.25 an email address for submission of comments from interested parties to provide input about  
126.26 the effectiveness of and continued need for the rulemaking procedures set out in subdivision  
126.27 2 and about the quality and effectiveness of rules adopted using these procedures. The  
126.28 commissioner shall seek comments by holding a meeting and by publishing a notice in the  
126.29 State Register that contains the date, time, and location of the meeting and a statement that  
126.30 invites oral or written comments. The notice must be published at least 30 days before the  
126.31 meeting date. The commissioner shall write a report summarizing the comments and shall  
126.32 submit the report to the Minnesota Health Data Institute and to the Minnesota Administrative  
127.1 Uniformity Committee by January 15 of every even-numbered year may seek additional  
127.2 input and provide additional opportunities for input as needed.

127.3 Sec. 4. Minnesota Statutes 2023 Supplement, section 62J.84, subdivision 10, is amended  
127.4 to read:

127.5 Subd. 10. **Notice of prescription drugs of substantial public interest.** (a) No later than  
127.6 January 31, 2024, and quarterly thereafter, the commissioner shall produce and post on the  
127.7 department's website a list of prescription drugs that the commissioner determines to represent  
127.8 a substantial public interest and for which the commissioner intends to request data under

146.9 data are past due. Any fine levied against the entity under this subdivision is subject to the  
146.10 contested case and judicial review provisions of sections 14.57 and 14.69.

146.11 (b) The commissioner may grant an entity an extension of or exemption from the reporting  
146.12 obligations under this subdivision, upon a showing of good cause by the entity.

146.13 Subd. 5. **Reports to the legislature.** By November 15, 2024, and by November 15 of  
146.14 each year thereafter, the commissioner shall submit to the chairs and ranking minority  
146.15 members of the legislative committees with jurisdiction over health care finance and policy,  
146.16 a report that aggregates the data submitted under subdivision 3, paragraphs (a) and (b). The  
146.17 following information must be included in the report for all 340B entities whose net 340B  
146.18 revenue constitutes a significant share, as determined by the commissioner, of all net 340B  
146.19 revenue across all 340B covered entities in Minnesota:

146.20 (1) the information submitted under subdivision 2; and

146.21 (2) for each 340B entity identified in subdivision 2, that entity's 340B net revenue as  
146.22 calculated using the data submitted under subdivision 3, paragraph (a), with net revenue  
146.23 being subdivision 3, paragraph (a), clause (2), less the sum of subdivision 3, paragraph (a),  
146.24 clauses (1) and (4).

146.25 For all other entities, the data in the report must be aggregated to the entity type or groupings  
146.26 of entity types in a manner that prevents the identification of an individual entity and any  
146.27 entity's specific data value reported for an individual data element.

146.28 Sec. 2. Minnesota Statutes 2022, section 62J.61, subdivision 5, is amended to read:

146.29 Subd. 5. ~~Biennial review of rulemaking procedures and rules~~ **Opportunity for**  
146.30 **comment.** The commissioner shall biennially seek comments from affected parties maintain  
146.31 an email address for submission of comments from interested parties to provide input about  
146.32 the effectiveness of and continued need for the rulemaking procedures set out in subdivision  
146.33 2 and about the quality and effectiveness of rules adopted using these procedures. The  
147.1 commissioner shall seek comments by holding a meeting and by publishing a notice in the  
147.2 State Register that contains the date, time, and location of the meeting and a statement that  
147.3 invites oral or written comments. The notice must be published at least 30 days before the  
147.4 meeting date. The commissioner shall write a report summarizing the comments and shall  
147.5 submit the report to the Minnesota Health Data Institute and to the Minnesota Administrative  
147.6 Uniformity Committee by January 15 of every even-numbered year may seek additional  
147.7 input and provide additional opportunities for input as needed.

127.9 subdivisions 11 to 14, subject to paragraph (c). The commissioner shall base its inclusion  
127.10 of prescription drugs on any information the commissioner determines is relevant to providing  
127.11 greater consumer awareness of the factors contributing to the cost of prescription drugs in  
127.12 the state, and the commissioner shall consider drug product families that include prescription  
127.13 drugs;

127.14 (1) that triggered reporting under subdivision 3 or 4 during the previous calendar quarter;

127.15 (2) for which average claims paid amounts exceeded 125 percent of the price as of the  
127.16 claim incurred date during the most recent calendar quarter for which claims paid amounts  
127.17 are available; or

127.18 (3) that are identified by members of the public during a public comment process.

127.19 (b) Not sooner than 30 days after publicly posting the list of prescription drugs under  
127.20 paragraph (a), the department shall notify, via email, reporting entities registered with the  
127.21 department of the requirement to report under subdivisions 11 to 14.

127.22 (c) The commissioner must not designate more than 500 prescription drugs as having a  
127.23 substantial public interest in any one notice.

127.24 (d) Notwithstanding subdivision 16, the commissioner is exempt from chapter 14,  
127.25 including section 14.386, in implementing this subdivision.

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

127.27 Sec. 5. Minnesota Statutes 2022, section 144.05, subdivision 6, is amended to read:

127.28 Subd. 6. **Reports on interagency agreements and intra-agency transfers.** The  
127.29 commissioner of health shall provide quarterly reports to the chairs and ranking minority  
127.30 members of the legislative committees with jurisdiction over health and human services  
127.31 policy and finance on:

128.1 (1) interagency agreements or service-level agreements and any renewals or extensions  
128.2 of existing interagency or service-level agreements with a state department under section  
128.3 15.01, state agency under section 15.012, or the Department of Information Technology  
128.4 Services, with a value of more than \$100,000, or related agreements with the same department  
128.5 or agency with a cumulative value of more than \$100,000; and

128.6 (2) transfers of appropriations of more than \$100,000 between accounts within or between  
128.7 agencies.

128.8 The report must include the statutory citation authorizing the agreement, transfer or dollar  
128.9 amount, purpose, and effective date of the agreement, and duration of the agreement, ~~and~~  
128.10 ~~a copy of the agreement.~~

108.17 Sec. 4. Minnesota Statutes 2022, section 144.05, subdivision 6, is amended to read:

108.18 Subd. 6. **Reports on interagency agreements and intra-agency transfers.** The  
108.19 commissioner of health shall provide ~~quarterly reports to the chairs and ranking minority~~  
108.20 ~~members of the legislative committees with jurisdiction over health and human services~~  
108.21 ~~policy and finance on;~~ the interagency agreements and intra-agency transfers report per  
108.22 section 15.0395.

108.23 (1) ~~interagency agreements or service-level agreements and any renewals or extensions~~  
108.24 ~~of existing interagency or service-level agreements with a state department under section~~  
108.25 ~~15.01, state agency under section 15.012, or the Department of Information Technology~~  
108.26 ~~Services, with a value of more than \$100,000, or related agreements with the same department~~  
108.27 ~~or agency with a cumulative value of more than \$100,000; and~~

108.28 (2) ~~transfers of appropriations of more than \$100,000 between accounts within or between~~  
108.29 ~~agencies.~~

109.1 ~~The report must include the statutory citation authorizing the agreement, transfer or dollar~~  
109.2 ~~amount, purpose, and effective date of the agreement, duration of the agreement, and a copy~~  
109.3 ~~of the agreement.~~

128.11 Sec. 6. Minnesota Statutes 2023 Supplement, section 144.0526, subdivision 1, is amended  
128.12 to read:

128.13 Subdivision 1. **Establishment.** The commissioner of health shall establish the Minnesota  
128.14 One Health Antimicrobial Stewardship Collaborative. The commissioner shall ~~appoint~~ hire  
128.15 a director to execute operations, conduct health education, and provide technical assistance.

128.16 Sec. 7. Minnesota Statutes 2022, section 144.058, is amended to read:

128.17 **144.058 INTERPRETER SERVICES QUALITY INITIATIVE.**

128.18 (a) The commissioner of health shall establish a voluntary statewide roster; and develop  
128.19 a plan for a registry and certification process for interpreters who provide high quality,  
128.20 spoken language health care interpreter services. The roster, registry, and certification  
128.21 process shall be based on the findings and recommendations set forth by the Interpreter  
128.22 Services Work Group required under Laws 2007, chapter 147, article 12, section 13.

128.23 (b) By January 1, 2009, the commissioner shall establish a roster of all available  
128.24 interpreters to address access concerns, particularly in rural areas.

128.25 (c) By January 15, 2010, the commissioner shall:

128.26 (1) develop a plan for a registry of spoken language health care interpreters, including:

147.8 Sec. 3. Minnesota Statutes 2022, section 144.05, subdivision 7, is amended to read:

147.9 Subd. 7. **Expiration of report mandates.** (a) If the submission of a report by the  
147.10 commissioner of health to the legislature is mandated by statute and the enabling legislation  
147.11 does not include a date for the submission of a final report, the mandate to submit the report  
147.12 shall expire in accordance with this section.

147.13 (b) If the mandate requires the submission of an annual report and the mandate was  
147.14 enacted before January 1, 2021, the mandate shall expire on January 1, 2023. If the mandate  
147.15 requires the submission of a biennial or less frequent report and the mandate was enacted  
147.16 before January 1, 2021, the mandate shall expire on January 1, 2024.

147.17 (c) Any reporting mandate enacted on or after January 1, 2021, shall expire three years  
147.18 after the date of enactment if the mandate requires the submission of an annual report and  
147.19 shall expire five years after the date of enactment if the mandate requires the submission  
147.20 of a biennial or less frequent report, unless the enacting legislation provides for a different  
147.21 expiration date.

147.22 (d) The commissioner shall submit a list to the chairs and ranking minority members of  
147.23 the legislative committees with jurisdiction over health by February 15 of each year,  
147.24 beginning February 15, 2022, of all reports set to expire during the following calendar year  
147.25 in accordance with this section. The mandate to submit a report to the legislature under this  
147.26 paragraph does not expire.

147.27 **EFFECTIVE DATE.** This section is effective retroactively from January 1, 2024.

147.28 Sec. 4. Minnesota Statutes 2023 Supplement, section 144.0526, subdivision 1, is amended  
147.29 to read:

147.30 Subdivision 1. **Establishment.** The commissioner of health shall establish the Minnesota  
147.31 One Health Antimicrobial Stewardship Collaborative. The commissioner shall ~~appoint~~ hire  
147.32 a director to execute operations, conduct health education, and provide technical assistance.

148.1 Sec. 5. Minnesota Statutes 2022, section 144.058, is amended to read:

148.2 **144.058 INTERPRETER SERVICES QUALITY INITIATIVE.**

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148.4 a plan for a registry and certification process for interpreters who provide high quality,  
148.5 spoken language health care interpreter services. The roster, registry, and certification  
148.6 process shall be based on the findings and recommendations set forth by the Interpreter  
148.7 Services Work Group required under Laws 2007, chapter 147, article 12, section 13.

148.8 (b) By January 1, 2009, the commissioner shall establish a roster of all available  
148.9 interpreters to address access concerns, particularly in rural areas.

148.10 (c) By January 15, 2010, the commissioner shall:

148.11 (1) develop a plan for a registry of spoken language health care interpreters, including:

128.27 (i) development of standards for registration that set forth educational requirements,  
128.28 training requirements, demonstration of language proficiency and interpreting skills,  
128.29 agreement to abide by a code of ethics, and a criminal background check;

128.30 (ii) recommendations for appropriate alternate requirements in languages for which  
128.31 testing and training programs do not exist;

129.1 (iii) recommendations for appropriate fees; and

129.2 (iv) recommendations for establishing and maintaining the standards for inclusion in  
129.3 the registry; and

129.4 (2) develop a plan for implementing a certification process based on national testing and  
129.5 certification processes for spoken language interpreters 12 months after the establishment  
129.6 of a national certification process.

129.7 (d) The commissioner shall consult with the Interpreter Stakeholder Group of the Upper  
129.8 Midwest Translators and Interpreters Association for advice on the standards required to  
129.9 plan for the development of a registry and certification process.

129.10 (e) The commissioner shall charge an annual fee of \$50 to include an interpreter in the  
129.11 roster. Fee revenue shall be deposited in the state government special revenue fund. All fees  
129.12 are nonrefundable.

129.13 Sec. 8. Minnesota Statutes 2022, section 144.0724, subdivision 2, is amended to read:

129.14 Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings  
129.15 given.

129.16 (a) "Assessment reference date" or "ARD" means the specific end point for look-back  
129.17 periods in the MDS assessment process. This look-back period is also called the observation  
129.18 or assessment period.

129.19 (b) "Case mix index" means the weighting factors assigned to the ~~RUG-IV~~ case mix  
129.20 reimbursement classifications determined by an assessment.

129.21 (c) "Index maximization" means classifying a resident who could be assigned to more  
129.22 than one category, to the category with the highest case mix index.

129.23 (d) "Minimum Data Set" or "MDS" means a core set of screening, clinical assessment,  
129.24 and functional status elements, that include common definitions and coding categories  
129.25 specified by the Centers for Medicare and Medicaid Services and designated by the  
129.26 Department of Health.

129.27 (e) "Representative" means a person who is the resident's guardian or conservator, the  
129.28 person authorized to pay the nursing home expenses of the resident, a representative of the  
129.29 Office of Ombudsman for Long-Term Care whose assistance has been requested, or any  
129.30 other individual designated by the resident.

148.12 (i) development of standards for registration that set forth educational requirements,  
148.13 training requirements, demonstration of language proficiency and interpreting skills,  
148.14 agreement to abide by a code of ethics, and a criminal background check;

148.15 (ii) recommendations for appropriate alternate requirements in languages for which  
148.16 testing and training programs do not exist;

148.17 (iii) recommendations for appropriate fees; and

148.18 (iv) recommendations for establishing and maintaining the standards for inclusion in  
148.19 the registry; and

148.20 (2) develop a plan for implementing a certification process based on national testing and  
148.21 certification processes for spoken language interpreters 12 months after the establishment  
148.22 of a national certification process.

148.23 (d) The commissioner shall consult with the Interpreter Stakeholder Group of the Upper  
148.24 Midwest Translators and Interpreters Association for advice on the standards required to  
148.25 plan for the development of a registry and certification process.

148.26 (e) The commissioner shall charge an annual fee of \$50 to include an interpreter in the  
148.27 roster. Fee revenue shall be deposited in the state government special revenue fund. All fees  
148.28 are nonrefundable.

148.29 Sec. 6. Minnesota Statutes 2022, section 144.0724, subdivision 2, is amended to read:

148.30 Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings  
148.31 given.

149.1 (a) "Assessment reference date" or "ARD" means the specific end point for look-back  
149.2 periods in the MDS assessment process. This look-back period is also called the observation  
149.3 or assessment period.

149.4 (b) "Case mix index" means the weighting factors assigned to the ~~RUG-IV~~ case mix  
149.5 reimbursement classifications determined by an assessment.

149.6 (c) "Index maximization" means classifying a resident who could be assigned to more  
149.7 than one category, to the category with the highest case mix index.

149.8 (d) "Minimum Data Set" or "MDS" means a core set of screening, clinical assessment,  
149.9 and functional status elements, that include common definitions and coding categories  
149.10 specified by the Centers for Medicare and Medicaid Services and designated by the  
149.11 Department of Health.

149.12 (e) "Representative" means a person who is the resident's guardian or conservator, the  
149.13 person authorized to pay the nursing home expenses of the resident, a representative of the  
149.14 Office of Ombudsman for Long-Term Care whose assistance has been requested, or any  
149.15 other individual designated by the resident.

130.1 ~~(f)~~ "Resource utilization groups" or "RUG" means the system for grouping a nursing  
130.2 facility's residents according to their clinical and functional status identified in data supplied  
130.3 by the facility's Minimum Data Set.

130.4 ~~(g)~~ (f) "Activities of daily living" includes personal hygiene, dressing, bathing,  
130.5 transferring, bed mobility, locomotion, eating, and toileting.

130.6 ~~(h)~~ (g) "Nursing facility level of care determination" means the assessment process that  
130.7 results in a determination of a resident's or prospective resident's need for nursing facility  
130.8 level of care as established in subdivision 11 for purposes of medical assistance payment  
130.9 of long-term care services for:

130.10 (1) nursing facility services under ~~section 256B.434~~ or chapter 256R;

130.11 (2) elderly waiver services under chapter 256S;

130.12 (3) CADI and BI waiver services under section 256B.49; and

130.13 (4) state payment of alternative care services under section 256B.0913.

130.14 Sec. 9. Minnesota Statutes 2022, section 144.0724, subdivision 3a, is amended to read:

130.15 Subd. 3a. **Resident reimbursement case mix reimbursement classifications beginning**  
130.16 **January 1, 2012.** (a) ~~Beginning January 1, 2012, Resident reimbursement case mix~~  
130.17 ~~reimbursement classifications shall be based on the Minimum Data Set, version 3.0~~  
130.18 ~~assessment instrument, or its successor version mandated by the Centers for Medicare and~~  
130.19 ~~Medicaid Services that nursing facilities are required to complete for all residents. The~~  
130.20 ~~commissioner of health shall establish resident classifications according to the RUG-IV,~~  
130.21 ~~48 group, resource utilization groups. Resident classification must be established based on~~  
130.22 ~~the individual items on the Minimum Data Set, which must be completed according to the~~  
130.23 ~~Long Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 or its~~  
130.24 ~~successor issued by the Centers for Medicare and Medicaid Services. Case mix~~  
130.25 ~~reimbursement classifications shall also be based on assessments required under subdivision~~  
130.26 ~~4. Assessments must be completed according to the Long Term Care Facility Resident~~  
130.27 ~~Assessment Instrument User's Manual Version 3.0 or a successor manual issued by the~~  
130.28 ~~Centers for Medicare and Medicaid Services. The optional state assessment must be~~  
130.29 ~~completed according to the OSA Manual Version 1.0 v.2.~~

130.30 (b) Each resident must be classified based on the information from the Minimum Data  
130.31 Set according to ~~the~~ general categories issued by the Minnesota Department of Health,  
130.32 utilized for reimbursement purposes.

131.1 Sec. 10. Minnesota Statutes 2022, section 144.0724, subdivision 4, is amended to read:

131.2 Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically  
131.3 submit to the federal database MDS assessments that conform with the assessment schedule  
131.4 defined by the Long Term Care Facility Resident Assessment Instrument User's Manual,  
131.5 version 3.0, or its successor issued by the Centers for Medicare and Medicaid Services. The

149.16 ~~(f)~~ "Resource utilization groups" or "RUG" means the system for grouping a nursing  
149.17 facility's residents according to their clinical and functional status identified in data supplied  
149.18 by the facility's Minimum Data Set.

149.19 ~~(g)~~ (f) "Activities of daily living" includes personal hygiene, dressing, bathing,  
149.20 transferring, bed mobility, locomotion, eating, and toileting.

149.21 ~~(h)~~ (g) "Nursing facility level of care determination" means the assessment process that  
149.22 results in a determination of a resident's or prospective resident's need for nursing facility  
149.23 level of care as established in subdivision 11 for purposes of medical assistance payment  
149.24 of long-term care services for:

149.25 (1) nursing facility services under ~~section 256B.434~~ or chapter 256R;

149.26 (2) elderly waiver services under chapter 256S;

149.27 (3) CADI and BI waiver services under section 256B.49; and

149.28 (4) state payment of alternative care services under section 256B.0913.

149.29 Sec. 7. Minnesota Statutes 2022, section 144.0724, subdivision 3a, is amended to read:

149.30 Subd. 3a. **Resident reimbursement case mix reimbursement classifications beginning**  
149.31 **January 1, 2012.** (a) ~~Beginning January 1, 2012, Resident reimbursement case mix~~  
150.1 ~~reimbursement classifications shall be based on the Minimum Data Set, version 3.0~~  
150.2 ~~assessment instrument, or its successor version mandated by the Centers for Medicare and~~  
150.3 ~~Medicaid Services that nursing facilities are required to complete for all residents. The~~  
150.4 ~~commissioner of health shall establish resident classifications according to the RUG-IV,~~  
150.5 ~~48 group, resource utilization groups. Resident classification must be established based on~~  
150.6 ~~the individual items on the Minimum Data Set, which must be completed according to the~~  
150.7 ~~Long Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 or its~~  
150.8 ~~successor issued by the Centers for Medicare and Medicaid Services. Case mix~~  
150.9 ~~reimbursement classifications shall also be based on assessments required under subdivision~~  
150.10 ~~4. Assessments must be completed according to the Long Term Care Facility Resident~~  
150.11 ~~Assessment Instrument User's Manual Version 3.0 or a successor manual issued by the~~  
150.12 ~~Centers for Medicare and Medicaid Services. The optional state assessment must be~~  
150.13 ~~completed according to the OSA Manual Version 1.0 v.2.~~

150.14 (b) Each resident must be classified based on the information from the Minimum Data  
150.15 Set according to ~~the~~ general categories issued by the Minnesota Department of Health,  
150.16 utilized for reimbursement purposes.

150.17 Sec. 8. Minnesota Statutes 2022, section 144.0724, subdivision 4, is amended to read:

150.18 Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically  
150.19 submit to the federal database MDS assessments that conform with the assessment schedule  
150.20 defined by the Long Term Care Facility Resident Assessment Instrument User's Manual,  
150.21 version 3.0, or its successor issued by the Centers for Medicare and Medicaid Services. The

131.6 commissioner of health may substitute successor manuals or question and answer documents  
131.7 published by the United States Department of Health and Human Services, Centers for  
131.8 Medicare and Medicaid Services, to replace or supplement the current version of the manual  
131.9 or document.

131.10 (b) The assessments required under the Omnibus Budget Reconciliation Act of 1987  
131.11 (OBRA) used to determine a case mix reimbursement classification ~~for reimbursement~~  
131.12 include:

131.13 (1) a new admission comprehensive assessment, which must have an assessment reference  
131.14 date (ARD) within 14 calendar days after admission, excluding readmissions;

131.15 (2) an annual comprehensive assessment, which must have an ARD within 92 days of  
131.16 a previous quarterly review assessment or a previous comprehensive assessment, which  
131.17 must occur at least once every 366 days;

131.18 (3) a significant change in status comprehensive assessment, which must have an ARD  
131.19 within 14 days after the facility determines, or should have determined, that there has been  
131.20 a significant change in the resident's physical or mental condition, whether an improvement  
131.21 or a decline, and regardless of the amount of time since the last comprehensive assessment  
131.22 or quarterly review assessment;

131.23 (4) a quarterly review assessment must have an ARD within 92 days of the ARD of the  
131.24 previous quarterly review assessment or a previous comprehensive assessment;

131.25 (5) any significant correction to a prior comprehensive assessment, if the assessment  
131.26 being corrected is the current one being used for ~~RUG~~ reimbursement classification;

131.27 (6) any significant correction to a prior quarterly review assessment, if the assessment  
131.28 being corrected is the current one being used for ~~RUG~~ reimbursement classification; and

131.29 ~~(7) a required significant change in status assessment when:~~

131.30 ~~(i) all speech, occupational, and physical therapies have ended. If the most recent OBRA~~  
131.31 ~~comprehensive or quarterly assessment completed does not result in a rehabilitation case~~  
131.32 ~~mix classification, then the significant change in status assessment is not required. The ARD~~  
131.33 ~~of this assessment must be set on day eight after all therapy services have ended; and~~

132.1 ~~(ii) isolation for an infectious disease has ended. If isolation was not coded on the most~~  
132.2 ~~recent OBRA comprehensive or quarterly assessment completed, then the significant change~~  
132.3 ~~in status assessment is not required. The ARD of this assessment must be set on day 15 after~~  
132.4 ~~isolation has ended; and~~

132.5 (8) ~~(7)~~ any modifications to the most recent assessments under clauses (1) to ~~(7)~~ (6).

132.6 (c) The optional state assessment must accompany all OBRA assessments. The optional  
132.7 state assessment is also required to determine reimbursement when:

150.22 commissioner of health may substitute successor manuals or question and answer documents  
150.23 published by the United States Department of Health and Human Services, Centers for  
150.24 Medicare and Medicaid Services, to replace or supplement the current version of the manual  
150.25 or document.

150.26 (b) The assessments required under the Omnibus Budget Reconciliation Act of 1987  
150.27 (OBRA) used to determine a case mix reimbursement classification ~~for reimbursement~~  
150.28 include:

150.29 (1) a new admission comprehensive assessment, which must have an assessment reference  
150.30 date (ARD) within 14 calendar days after admission, excluding readmissions;

150.31 (2) an annual comprehensive assessment, which must have an ARD within 92 days of  
150.32 a previous quarterly review assessment or a previous comprehensive assessment, which  
150.33 must occur at least once every 366 days;

151.1 (3) a significant change in status comprehensive assessment, which must have an ARD  
151.2 within 14 days after the facility determines, or should have determined, that there has been  
151.3 a significant change in the resident's physical or mental condition, whether an improvement  
151.4 or a decline, and regardless of the amount of time since the last comprehensive assessment  
151.5 or quarterly review assessment;

151.6 (4) a quarterly review assessment must have an ARD within 92 days of the ARD of the  
151.7 previous quarterly review assessment or a previous comprehensive assessment;

151.8 (5) any significant correction to a prior comprehensive assessment, if the assessment  
151.9 being corrected is the current one being used for ~~RUG~~ reimbursement classification;

151.10 (6) any significant correction to a prior quarterly review assessment, if the assessment  
151.11 being corrected is the current one being used for ~~RUG~~ reimbursement classification; and

151.12 ~~(7) a required significant change in status assessment when:~~

151.13 ~~(i) all speech, occupational, and physical therapies have ended. If the most recent OBRA~~  
151.14 ~~comprehensive or quarterly assessment completed does not result in a rehabilitation case~~  
151.15 ~~mix classification, then the significant change in status assessment is not required. The ARD~~  
151.16 ~~of this assessment must be set on day eight after all therapy services have ended; and~~

151.17 ~~(ii) isolation for an infectious disease has ended. If isolation was not coded on the most~~  
151.18 ~~recent OBRA comprehensive or quarterly assessment completed, then the significant change~~  
151.19 ~~in status assessment is not required. The ARD of this assessment must be set on day 15 after~~  
151.20 ~~isolation has ended; and~~

151.21 (8) ~~(7)~~ any modifications to the most recent assessments under clauses (1) to ~~(7)~~ (6).

151.22 (c) The optional state assessment must accompany all OBRA assessments. The optional  
151.23 state assessment is also required to determine reimbursement when:



132.8 (i) all speech, occupational, and physical therapies have ended. If the most recent optional  
132.9 state assessment completed does not result in a rehabilitation case mix reimbursement  
132.10 classification, then the optional state assessment is not required. The ARD of this assessment  
132.11 must be set on day eight after all therapy services have ended; and

132.12 (ii) isolation for an infectious disease has ended. If isolation was not coded on the most  
132.13 recent optional state assessment completed, then the optional state assessment is not required.  
132.14 The ARD of this assessment must be set on day 15 after isolation has ended.

132.15 ~~(c)~~ (d) In addition to the assessments listed in ~~paragraph~~ paragraphs (b) and (c), the  
132.16 assessments used to determine nursing facility level of care include the following:

132.17 (1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by  
132.18 the Senior LinkAge Line or other organization under contract with the Minnesota Board on  
132.19 Aging; and

132.20 (2) a nursing facility level of care determination as provided for under section 256B.0911,  
132.21 subdivision 26, as part of a face-to-face long-term care consultation assessment completed  
132.22 under section 256B.0911, by a county, tribe, or managed care organization under contract  
132.23 with the Department of Human Services.

132.24 Sec. 11. Minnesota Statutes 2022, section 144.0724, subdivision 6, is amended to read:

132.25 Subd. 6. **Penalties for late or nonsubmission.** (a) A facility that fails to complete or  
132.26 submit an assessment according to subdivisions 4 and 5 for a ~~RUG-IV~~ case mix  
132.27 reimbursement classification ~~within seven days of the time requirements listed in the~~  
132.28 ~~Long-Term Care Facility Resident Assessment Instrument User's Manual when the~~  
132.29 assessment is due is subject to a reduced rate for that resident. The reduced rate shall be the  
132.30 lowest rate for that facility. The reduced rate is effective on the day of admission for new  
132.31 admission assessments, on the ARD for significant change in status assessments, or on the  
132.32 day that the assessment was due for all other assessments and continues in effect until the  
133.1 first day of the month following the date of submission and acceptance of the resident's  
133.2 assessment.

133.3 (b) If loss of revenue due to penalties incurred by a facility for any period of 92 days  
133.4 are equal to or greater than 0.1 percent of the total operating costs on the facility's most  
133.5 recent annual statistical and cost report, a facility may apply to the commissioner of human  
133.6 services for a reduction in the total penalty amount. The commissioner of human services,  
133.7 in consultation with the commissioner of health, may, at the sole discretion of the  
133.8 commissioner of human services, limit the penalty for residents covered by medical assistance  
133.9 to ten days.

133.10 Sec. 12. Minnesota Statutes 2022, section 144.0724, subdivision 7, is amended to read:

133.11 Subd. 7. **Notice of resident reimbursement case mix reimbursement classification.** (a)  
133.12 The commissioner of health shall provide to a nursing facility a notice for each resident of  
133.13 the classification established under subdivision 1. The notice must inform the resident of

151.24 (i) all speech, occupational, and physical therapies have ended. If the most recent optional  
151.25 state assessment completed does not result in a rehabilitation case mix reimbursement  
151.26 classification, then the optional state assessment is not required. The ARD of this assessment  
151.27 must be set on day eight after all therapy services have ended; and

151.28 (ii) isolation for an infectious disease has ended. If isolation was not coded on the most  
151.29 recent optional state assessment completed, then the optional state assessment is not required.  
151.30 The ARD of this assessment must be set on day 15 after isolation has ended.

151.31 ~~(c)~~ (d) In addition to the assessments listed in ~~paragraph~~ paragraphs (b) and (c), the  
151.32 assessments used to determine nursing facility level of care include the following:

152.1 (1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by  
152.2 the Senior LinkAge Line or other organization under contract with the Minnesota Board on  
152.3 Aging; and

152.4 (2) a nursing facility level of care determination as provided for under section 256B.0911,  
152.5 subdivision 26, as part of a face-to-face long-term care consultation assessment completed  
152.6 under section 256B.0911, by a county, tribe, or managed care organization under contract  
152.7 with the Department of Human Services.

152.8 Sec. 9. Minnesota Statutes 2022, section 144.0724, subdivision 6, is amended to read:

152.9 Subd. 6. **Penalties for late or nonsubmission.** (a) A facility that fails to complete or  
152.10 submit an assessment according to subdivisions 4 and 5 for a ~~RUG-IV~~ case mix  
152.11 reimbursement classification ~~within seven days of the time requirements listed in the~~  
152.12 ~~Long-Term Care Facility Resident Assessment Instrument User's Manual when the~~  
152.13 assessment is due is subject to a reduced rate for that resident. The reduced rate shall be the  
152.14 lowest rate for that facility. The reduced rate is effective on the day of admission for new  
152.15 admission assessments, on the ARD for significant change in status assessments, or on the  
152.16 day that the assessment was due for all other assessments and continues in effect until the  
152.17 first day of the month following the date of submission and acceptance of the resident's  
152.18 assessment.

152.19 (b) If loss of revenue due to penalties incurred by a facility for any period of 92 days  
152.20 are equal to or greater than 0.1 percent of the total operating costs on the facility's most  
152.21 recent annual statistical and cost report, a facility may apply to the commissioner of human  
152.22 services for a reduction in the total penalty amount. The commissioner of human services,  
152.23 in consultation with the commissioner of health, may, at the sole discretion of the  
152.24 commissioner of human services, limit the penalty for residents covered by medical assistance  
152.25 to ten days.

152.26 Sec. 10. Minnesota Statutes 2022, section 144.0724, subdivision 7, is amended to read:

152.27 Subd. 7. **Notice of resident reimbursement case mix reimbursement classification.** (a)  
152.28 The commissioner of health shall provide to a nursing facility a notice for each resident of  
152.29 the classification established under subdivision 1. The notice must inform the resident of

133.14 the case mix reimbursement classification assigned, the opportunity to review the  
133.15 documentation supporting the classification, the opportunity to obtain clarification from the  
133.16 commissioner, ~~and~~ the opportunity to request a reconsideration of the classification, and  
133.17 the address and telephone number of the Office of Ombudsman for Long-Term Care. The  
133.18 commissioner must transmit the notice of resident classification by electronic means to the  
133.19 nursing facility. The nursing facility is responsible for the distribution of the notice to each  
133.20 resident or the resident's representative. This notice must be distributed within three business  
133.21 days after the facility's receipt.

133.22 (b) If a facility submits a ~~modifying~~ modified assessment resulting in a change in the  
133.23 case mix reimbursement classification, the facility must provide a written notice to the  
133.24 resident or the resident's representative regarding the item or items that were modified and  
133.25 the reason for the modifications. The written notice must be provided within three business  
133.26 days after distribution of the resident case mix reimbursement classification notice.

133.27 Sec. 13. Minnesota Statutes 2022, section 144.0724, subdivision 8, is amended to read:

133.28 Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, ~~or~~  
133.29 resident's representative, ~~or~~ the nursing facility, or the boarding care home may request that  
133.30 the commissioner of health reconsider the assigned ~~reimbursement~~ case mix reimbursement  
133.31 classification and any item or items changed during the audit process. The request for  
133.32 reconsideration must be submitted in writing to the commissioner of health.

133.33 (b) For reconsideration requests initiated by the resident or the resident's representative:

134.1 (1) The resident or the resident's representative must submit in writing a reconsideration  
134.2 request to the facility administrator within 30 days of receipt of the resident classification  
134.3 notice. The written request must include the reasons for the reconsideration request.

134.4 (2) Within three business days of receiving the reconsideration request, the nursing  
134.5 facility must submit to the commissioner of health a completed reconsideration request  
134.6 form, a copy of the resident's or resident's representative's written request, and all supporting  
134.7 documentation used to complete the assessment being ~~considered~~ reconsidered. If the facility  
134.8 fails to provide the required information, the reconsideration will be completed with the  
134.9 information submitted and the facility cannot make further reconsideration requests on this  
134.10 classification.

134.11 (3) Upon written request and within three business days, the nursing facility must give  
134.12 the resident or the resident's representative a copy of the assessment being reconsidered and  
134.13 all supporting documentation used to complete the assessment. Notwithstanding any law  
134.14 to the contrary, the facility may not charge a fee for providing copies of the requested  
134.15 documentation. If a facility fails to provide the required documents within this time, it is  
134.16 subject to the issuance of a correction order and penalty assessment under sections 144.653  
134.17 and 144A.10. Notwithstanding those sections, any correction order issued under this  
134.18 subdivision must require that the nursing facility immediately comply with the request for  
134.19 information, and as of the date of the issuance of the correction order, the facility shall

152.30 the case mix reimbursement classification assigned, the opportunity to review the  
152.31 documentation supporting the classification, the opportunity to obtain clarification from the  
152.32 commissioner, ~~and~~ the opportunity to request a reconsideration of the classification, and  
152.33 the address and telephone number of the Office of Ombudsman for Long-Term Care. The  
153.1 commissioner must transmit the notice of resident classification by electronic means to the  
153.2 nursing facility. The nursing facility is responsible for the distribution of the notice to each  
153.3 resident or the resident's representative. This notice must be distributed within three business  
153.4 days after the facility's receipt.

153.5 (b) If a facility submits a ~~modifying~~ modified assessment resulting in a change in the  
153.6 case mix reimbursement classification, the facility must provide a written notice to the  
153.7 resident or the resident's representative regarding the item or items that were modified and  
153.8 the reason for the modifications. The written notice must be provided within three business  
153.9 days after distribution of the resident case mix reimbursement classification notice.

153.10 Sec. 11. Minnesota Statutes 2022, section 144.0724, subdivision 8, is amended to read:

153.11 Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, ~~or~~  
153.12 ~~the~~ resident's representative, ~~or~~ the nursing facility, or the boarding care home may request  
153.13 that the commissioner of health reconsider the assigned ~~reimbursement~~ case mix  
153.14 reimbursement classification and any item or items changed during the audit process. The  
153.15 request for reconsideration must be submitted in writing to the commissioner of health.

153.16 (b) For reconsideration requests initiated by the resident or the resident's representative:

153.17 (1) The resident or the resident's representative must submit in writing a reconsideration  
153.18 request to the facility administrator within 30 days of receipt of the resident classification  
153.19 notice. The written request must include the reasons for the reconsideration request.

153.20 (2) Within three business days of receiving the reconsideration request, the nursing  
153.21 facility must submit to the commissioner of health a completed reconsideration request  
153.22 form, a copy of the resident's or resident's representative's written request, and all supporting  
153.23 documentation used to complete the assessment being ~~considered~~ reconsidered. If the facility  
153.24 fails to provide the required information, the reconsideration will be completed with the  
153.25 information submitted and the facility cannot make further reconsideration requests on this  
153.26 classification.

153.27 (3) Upon written request and within three business days, the nursing facility must give  
153.28 the resident or the resident's representative a copy of the assessment being reconsidered and  
153.29 all supporting documentation used to complete the assessment. Notwithstanding any law  
153.30 to the contrary, the facility may not charge a fee for providing copies of the requested  
153.31 documentation. If a facility fails to provide the required documents within this time, it is  
153.32 subject to the issuance of a correction order and penalty assessment under sections 144.653  
153.33 and 144A.10. Notwithstanding those sections, any correction order issued under this  
154.1 subdivision must require that the nursing facility immediately comply with the request for  
154.2 information, and as of the date of the issuance of the correction order, the facility shall

134.20 forfeit to the state a \$100 fine for the first day of noncompliance, and an increase in the  
134.21 \$100 fine by \$50 increments for each day the noncompliance continues.

134.22 (c) For reconsideration requests initiated by the facility:

134.23 (1) The facility is required to inform the resident or the resident's representative in writing  
134.24 that a reconsideration of the resident's case mix reimbursement classification is being  
134.25 requested. The notice must inform the resident or the resident's representative:

134.26 (i) of the date and reason for the reconsideration request;

134.27 (ii) of the potential for a case mix reimbursement classification change and subsequent  
134.28 rate change;

134.29 (iii) of the extent of the potential rate change;

134.30 (iv) that copies of the request and supporting documentation are available for review;  
134.31 and

134.32 (v) that the resident or the resident's representative has the right to request a  
134.33 reconsideration also.

135.1 (2) Within 30 days of receipt of the audit exit report or resident classification notice, the  
135.2 facility must submit to the commissioner of health a completed reconsideration request  
135.3 form, all supporting documentation used to complete the assessment being reconsidered,  
135.4 and a copy of the notice informing the resident or the resident's representative that a  
135.5 reconsideration of the resident's classification is being requested.

135.6 (3) If the facility fails to provide the required information, the reconsideration request  
135.7 may be denied and the facility may not make further reconsideration requests on this  
135.8 classification.

135.9 (d) Reconsideration by the commissioner must be made by individuals not involved in  
135.10 reviewing the assessment, audit, or reconsideration that established the disputed classification.  
135.11 The reconsideration must be based upon the assessment that determined the classification  
135.12 and upon the information provided to the commissioner of health under paragraphs (a) to  
135.13 (c). If necessary for evaluating the reconsideration request, the commissioner may conduct  
135.14 on-site reviews. Within 15 business days of receiving the request for reconsideration, the  
135.15 commissioner shall affirm or modify the original resident classification. The original  
135.16 classification must be modified if the commissioner determines that the assessment resulting  
135.17 in the classification did not accurately reflect characteristics of the resident at the time of  
135.18 the assessment. The commissioner must transmit the reconsideration classification notice  
135.19 by electronic means to the nursing facility. The nursing facility is responsible for the  
135.20 distribution of the notice to the resident or the resident's representative. The notice must be  
135.21 distributed by the nursing facility within three business days after receipt. A decision by  
135.22 the commissioner under this subdivision is the final administrative decision of the agency  
135.23 for the party requesting reconsideration.

154.3 forfeit to the state a \$100 fine for the first day of noncompliance, and an increase in the  
154.4 \$100 fine by \$50 increments for each day the noncompliance continues.

154.5 (c) For reconsideration requests initiated by the facility:

154.6 (1) The facility is required to inform the resident or the resident's representative in writing  
154.7 that a reconsideration of the resident's case mix reimbursement classification is being  
154.8 requested. The notice must inform the resident or the resident's representative:

154.9 (i) of the date and reason for the reconsideration request;

154.10 (ii) of the potential for a case mix reimbursement classification change and subsequent  
154.11 rate change;

154.12 (iii) of the extent of the potential rate change;

154.13 (iv) that copies of the request and supporting documentation are available for review;  
154.14 and

154.15 (v) that the resident or the resident's representative has the right to request a  
154.16 reconsideration also.

154.17 (2) Within 30 days of receipt of the audit exit report or resident classification notice, the  
154.18 facility must submit to the commissioner of health a completed reconsideration request  
154.19 form, all supporting documentation used to complete the assessment being reconsidered,  
154.20 and a copy of the notice informing the resident or the resident's representative that a  
154.21 reconsideration of the resident's classification is being requested.

154.22 (3) If the facility fails to provide the required information, the reconsideration request  
154.23 may be denied and the facility may not make further reconsideration requests on this  
154.24 classification.

154.25 (d) Reconsideration by the commissioner must be made by individuals not involved in  
154.26 reviewing the assessment, audit, or reconsideration that established the disputed classification.  
154.27 The reconsideration must be based upon the assessment that determined the classification  
154.28 and upon the information provided to the commissioner of health under paragraphs (a) to  
154.29 (c). If necessary for evaluating the reconsideration request, the commissioner may conduct  
154.30 on-site reviews. Within 15 business days of receiving the request for reconsideration, the  
154.31 commissioner shall affirm or modify the original resident classification. The original  
154.32 classification must be modified if the commissioner determines that the assessment resulting  
154.33 in the classification did not accurately reflect characteristics of the resident at the time of  
155.1 the assessment. The commissioner must transmit the reconsideration classification notice  
155.2 by electronic means to the nursing facility. The nursing facility is responsible for the  
155.3 distribution of the notice to the resident or the resident's representative. The notice must be  
155.4 distributed by the nursing facility within three business days after receipt. A decision by  
155.5 the commissioner under this subdivision is the final administrative decision of the agency  
155.6 for the party requesting reconsideration.

135.24 (e) The case mix reimbursement classification established by the commissioner shall be  
135.25 the classification which applies to the resident while the request for reconsideration is  
135.26 pending. If a request for reconsideration applies to an assessment used to determine nursing  
135.27 facility level of care under subdivision 4, paragraph ~~(e)~~ (d), the resident shall continue to  
135.28 be eligible for nursing facility level of care while the request for reconsideration is pending.

135.29 (f) The commissioner may request additional documentation regarding a reconsideration  
135.30 necessary to make an accurate reconsideration determination.

135.31 (g) Data collected as part of the reconsideration process under this section is classified  
135.32 as private data on individuals and nonpublic data pursuant to section 13.02. Notwithstanding  
135.33 the classification of these data as private or nonpublic, the commissioner is authorized to  
136.1 share these data with the U.S. Centers for Medicare and Medicaid Services and the  
136.2 commissioner of human services as necessary for reimbursement purposes.

136.3 Sec. 14. Minnesota Statutes 2022, section 144.0724, subdivision 9, is amended to read:

136.4 Subd. 9. **Audit authority.** (a) The commissioner shall audit the accuracy of resident  
136.5 assessments performed under section 256R.17 through any of the following: desk audits;  
136.6 on-site review of residents and their records; and interviews with staff, residents, or residents'  
136.7 families. The commissioner shall reclassify a resident if the commissioner determines that  
136.8 the resident was incorrectly classified.

136.9 (b) The commissioner is authorized to conduct on-site audits on an unannounced basis.

136.10 (c) A facility must grant the commissioner access to examine the medical records relating  
136.11 to the resident assessments selected for audit under this subdivision. The commissioner may  
136.12 also observe and speak to facility staff and residents.

136.13 (d) The commissioner shall consider documentation under the time frames for coding  
136.14 items on the minimum data set as set out in the Long-Term Care Facility Resident Assessment  
136.15 Instrument User's Manual or OSA Manual version 1.0 v.2 published by the Centers for  
136.16 Medicare and Medicaid Services.

136.17 (e) The commissioner shall develop an audit selection procedure that includes the  
136.18 following factors:

136.19 (1) Each facility shall be audited annually. If a facility has two successive audits in which  
136.20 the percentage of change is five percent or less and the facility has not been the subject of  
136.21 a special audit in the past 36 months, the facility may be audited biannually. A stratified  
136.22 sample of 15 percent, with a minimum of ten assessments, of the most current assessments  
136.23 shall be selected for audit. If more than 20 percent of the ~~RUG-IV~~ case mix reimbursement  
136.24 classifications are changed as a result of the audit, the audit shall be expanded to a second  
136.25 15 percent sample, with a minimum of ten assessments. If the total change between the first  
136.26 and second samples is 35 percent or greater, the commissioner may expand the audit to all  
136.27 of the remaining assessments.

155.7 (e) The case mix reimbursement classification established by the commissioner shall be  
155.8 the classification which applies to the resident while the request for reconsideration is  
155.9 pending. If a request for reconsideration applies to an assessment used to determine nursing  
155.10 facility level of care under subdivision 4, paragraph ~~(e)~~ (d), the resident shall continue to  
155.11 be eligible for nursing facility level of care while the request for reconsideration is pending.

155.12 (f) The commissioner may request additional documentation regarding a reconsideration  
155.13 necessary to make an accurate reconsideration determination.

155.14 (g) Data collected as part of the reconsideration process under this section is classified  
155.15 as private data on individuals and nonpublic data pursuant to section 13.02. Notwithstanding  
155.16 the classification of these data as private or nonpublic, the commissioner is authorized to  
155.17 share these data with the U.S. Centers for Medicare and Medicaid Services and the  
155.18 commissioner of human services as necessary for reimbursement purposes.

155.19 Sec. 12. Minnesota Statutes 2022, section 144.0724, subdivision 9, is amended to read:

155.20 Subd. 9. **Audit authority.** (a) The commissioner shall audit the accuracy of resident  
155.21 assessments performed under section 256R.17 through any of the following: desk audits;  
155.22 on-site review of residents and their records; and interviews with staff, residents, or residents'  
155.23 families. The commissioner shall reclassify a resident if the commissioner determines that  
155.24 the resident was incorrectly classified.

155.25 (b) The commissioner is authorized to conduct on-site audits on an unannounced basis.

155.26 (c) A facility must grant the commissioner access to examine the medical records relating  
155.27 to the resident assessments selected for audit under this subdivision. The commissioner may  
155.28 also observe and speak to facility staff and residents.

155.29 (d) The commissioner shall consider documentation under the time frames for coding  
155.30 items on the minimum data set as set out in the Long-Term Care Facility Resident Assessment  
155.31 Instrument User's Manual or OSA Manual version 1.0 v.2 published by the Centers for  
155.32 Medicare and Medicaid Services.

156.1 (e) The commissioner shall develop an audit selection procedure that includes the  
156.2 following factors:

156.3 (1) Each facility shall be audited annually. If a facility has two successive audits in which  
156.4 the percentage of change is five percent or less and the facility has not been the subject of  
156.5 a special audit in the past 36 months, the facility may be audited biannually. A stratified  
156.6 sample of 15 percent, with a minimum of ten assessments, of the most current assessments  
156.7 shall be selected for audit. If more than 20 percent of the ~~RUG-IV~~ case mix reimbursement  
156.8 classifications are changed as a result of the audit, the audit shall be expanded to a second  
156.9 15 percent sample, with a minimum of ten assessments. If the total change between the first  
156.10 and second samples is 35 percent or greater, the commissioner may expand the audit to all  
156.11 of the remaining assessments.

136.28 (2) If a facility qualifies for an expanded audit, the commissioner may audit the facility  
136.29 again within six months. If a facility has two expanded audits within a 24-month period,  
136.30 that facility will be audited at least every six months for the next 18 months.

136.31 (3) The commissioner may conduct special audits if the commissioner determines that  
136.32 circumstances exist that could alter or affect the validity of case mix reimbursement  
136.33 classifications of residents. These circumstances include, but are not limited to, the following:

137.1 (i) frequent changes in the administration or management of the facility;

137.2 (ii) an unusually high percentage of residents in a specific case mix reimbursement  
137.3 classification;

137.4 (iii) a high frequency in the number of reconsideration requests received from a facility;

137.5 (iv) frequent adjustments of case mix reimbursement classifications as the result of  
137.6 reconsiderations or audits;

137.7 (v) a criminal indictment alleging provider fraud;

137.8 (vi) other similar factors that relate to a facility's ability to conduct accurate assessments;

137.9 (vii) an atypical pattern of scoring minimum data set items;

137.10 (viii) nonsubmission of assessments;

137.11 (ix) late submission of assessments; or

137.12 (x) a previous history of audit changes of 35 percent or greater.

137.13 (f) If the audit results in a case mix reimbursement classification change, the  
137.14 commissioner must transmit the audit classification notice by electronic means to the nursing  
137.15 facility within 15 business days of completing an audit. The nursing facility is responsible  
137.16 for distribution of the notice to each resident or the resident's representative. This notice  
137.17 must be distributed by the nursing facility within three business days after receipt. The  
137.18 notice must inform the resident of the case mix reimbursement classification assigned, the  
137.19 opportunity to review the documentation supporting the classification, the opportunity to  
137.20 obtain clarification from the commissioner, the opportunity to request a reconsideration of  
137.21 the classification, and the address and telephone number of the Office of Ombudsman for  
137.22 Long-Term Care.

137.23 Sec. 15. Minnesota Statutes 2022, section 144.0724, subdivision 11, is amended to read:

137.24 Subd. 11. **Nursing facility level of care.** (a) For purposes of medical assistance payment  
137.25 of long-term care services, a recipient must be determined, using assessments defined in  
137.26 subdivision 4, to meet one of the following nursing facility level of care criteria:

137.27 (1) the person requires formal clinical monitoring at least once per day;

156.12 (2) If a facility qualifies for an expanded audit, the commissioner may audit the facility  
156.13 again within six months. If a facility has two expanded audits within a 24-month period,  
156.14 that facility will be audited at least every six months for the next 18 months.

156.15 (3) The commissioner may conduct special audits if the commissioner determines that  
156.16 circumstances exist that could alter or affect the validity of case mix reimbursement  
156.17 classifications of residents. These circumstances include, but are not limited to, the following:

156.18 (i) frequent changes in the administration or management of the facility;

156.19 (ii) an unusually high percentage of residents in a specific case mix reimbursement  
156.20 classification;

156.21 (iii) a high frequency in the number of reconsideration requests received from a facility;

156.22 (iv) frequent adjustments of case mix reimbursement classifications as the result of  
156.23 reconsiderations or audits;

156.24 (v) a criminal indictment alleging provider fraud;

156.25 (vi) other similar factors that relate to a facility's ability to conduct accurate assessments;

156.26 (vii) an atypical pattern of scoring minimum data set items;

156.27 (viii) nonsubmission of assessments;

156.28 (ix) late submission of assessments; or

156.29 (x) a previous history of audit changes of 35 percent or greater.

156.30 (f) If the audit results in a case mix reimbursement classification change, the  
156.31 commissioner must transmit the audit classification notice by electronic means to the nursing  
157.1 facility within 15 business days of completing an audit. The nursing facility is responsible  
157.2 for distribution of the notice to each resident or the resident's representative. This notice  
157.3 must be distributed by the nursing facility within three business days after receipt. The  
157.4 notice must inform the resident of the case mix reimbursement classification assigned, the  
157.5 opportunity to review the documentation supporting the classification, the opportunity to  
157.6 obtain clarification from the commissioner, the opportunity to request a reconsideration of  
157.7 the classification, and the address and telephone number of the Office of Ombudsman for  
157.8 Long-Term Care.

157.9 Sec. 13. Minnesota Statutes 2022, section 144.0724, subdivision 11, is amended to read:

157.10 Subd. 11. **Nursing facility level of care.** (a) For purposes of medical assistance payment  
157.11 of long-term care services, a recipient must be determined, using assessments defined in  
157.12 subdivision 4, to meet one of the following nursing facility level of care criteria:

157.13 (1) the person requires formal clinical monitoring at least once per day;

137.28 (2) the person needs the assistance of another person or constant supervision to begin  
137.29 and complete at least four of the following activities of living: bathing, bed mobility, dressing,  
137.30 eating, grooming, toileting, transferring, and walking;

138.1 (3) the person needs the assistance of another person or constant supervision to begin  
138.2 and complete toileting, transferring, or positioning and the assistance cannot be scheduled;

138.3 (4) the person has significant difficulty with memory, using information, daily decision  
138.4 making, or behavioral needs that require intervention;

138.5 (5) the person has had a qualifying nursing facility stay of at least 90 days;

138.6 (6) the person meets the nursing facility level of care criteria determined 90 days after  
138.7 admission or on the first quarterly assessment after admission, whichever is later; or

138.8 (7) the person is determined to be at risk for nursing facility admission or readmission  
138.9 through a face-to-face long-term care consultation assessment as specified in section  
138.10 256B.0911, subdivision 17 to 21, 23, 24, 27, or 28, by a county, tribe, or managed care  
138.11 organization under contract with the Department of Human Services. The person is  
138.12 considered at risk under this clause if the person currently lives alone or will live alone or  
138.13 be homeless without the person's current housing and also meets one of the following criteria:

138.14 (i) the person has experienced a fall resulting in a fracture;

138.15 (ii) the person has been determined to be at risk of maltreatment or neglect, including  
138.16 self-neglect; or

138.17 (iii) the person has a sensory impairment that substantially impacts functional ability  
138.18 and maintenance of a community residence.

138.19 (b) The assessment used to establish medical assistance payment for nursing facility  
138.20 services must be the most recent assessment performed under subdivision 4, ~~paragraph~~  
138.21 ~~paragraphs (b) and (c)~~, that occurred no more than 90 calendar days before the effective  
138.22 date of medical assistance eligibility for payment of long-term care services. In no case  
138.23 shall medical assistance payment for long-term care services occur prior to the date of the  
138.24 determination of nursing facility level of care.

138.25 (c) The assessment used to establish medical assistance payment for long-term care  
138.26 services provided under chapter 256S and section 256B.49 and alternative care payment  
138.27 for services provided under section 256B.0913 must be the most recent face-to-face  
138.28 assessment performed under section 256B.0911, subdivisions 17 to 21, 23, 24, 27, or 28,  
138.29 that occurred no more than 60 calendar days before the effective date of medical assistance  
138.30 eligibility for payment of long-term care services.

139.1 Sec. 16. Minnesota Statutes 2022, section 144.1464, subdivision 1, is amended to read:

139.2 Subdivision 1. **Summer internships.** The commissioner of health, through a contract  
139.3 with a nonprofit organization as required by subdivision 4, shall award grants, within

157.14 (2) the person needs the assistance of another person or constant supervision to begin  
157.15 and complete at least four of the following activities of living: bathing, bed mobility, dressing,  
157.16 eating, grooming, toileting, transferring, and walking;

157.17 (3) the person needs the assistance of another person or constant supervision to begin  
157.18 and complete toileting, transferring, or positioning and the assistance cannot be scheduled;

157.19 (4) the person has significant difficulty with memory, using information, daily decision  
157.20 making, or behavioral needs that require intervention;

157.21 (5) the person has had a qualifying nursing facility stay of at least 90 days;

157.22 (6) the person meets the nursing facility level of care criteria determined 90 days after  
157.23 admission or on the first quarterly assessment after admission, whichever is later; or

157.24 (7) the person is determined to be at risk for nursing facility admission or readmission  
157.25 through a face-to-face long-term care consultation assessment as specified in section  
157.26 256B.0911, subdivision 17 to 21, 23, 24, 27, or 28, by a county, tribe, or managed care  
157.27 organization under contract with the Department of Human Services. The person is  
157.28 considered at risk under this clause if the person currently lives alone or will live alone or  
157.29 be homeless without the person's current housing and also meets one of the following criteria:

157.30 (i) the person has experienced a fall resulting in a fracture;

157.31 (ii) the person has been determined to be at risk of maltreatment or neglect, including  
157.32 self-neglect; or

158.1 (iii) the person has a sensory impairment that substantially impacts functional ability  
158.2 and maintenance of a community residence.

158.3 (b) The assessment used to establish medical assistance payment for nursing facility  
158.4 services must be the most recent assessment performed under subdivision 4, ~~paragraph~~  
158.5 ~~paragraphs (b) and (c)~~, that occurred no more than 90 calendar days before the effective  
158.6 date of medical assistance eligibility for payment of long-term care services. In no case  
158.7 shall medical assistance payment for long-term care services occur prior to the date of the  
158.8 determination of nursing facility level of care.

158.9 (c) The assessment used to establish medical assistance payment for long-term care  
158.10 services provided under chapter 256S and section 256B.49 and alternative care payment  
158.11 for services provided under section 256B.0913 must be the most recent face-to-face  
158.12 assessment performed under section 256B.0911, subdivisions 17 to 21, 23, 24, 27, or 28,  
158.13 that occurred no more than 60 calendar days before the effective date of medical assistance  
158.14 eligibility for payment of long-term care services.

158.15 Sec. 14. Minnesota Statutes 2022, section 144.1464, subdivision 1, is amended to read:

158.16 Subdivision 1. **Summer internships.** The commissioner of health, through a contract  
158.17 with a nonprofit organization as required by subdivision 4, shall award grants, within

139.4 available appropriations, to hospitals, clinics, nursing facilities, assisted living facilities,  
139.5 and home care providers to establish a secondary and postsecondary summer health care  
139.6 intern program. The purpose of the program is to expose interested secondary and  
139.7 postsecondary pupils to various careers within the health care profession.

139.8 Sec. 17. Minnesota Statutes 2022, section 144.1464, subdivision 2, is amended to read:

139.9 Subd. 2. **Criteria.** (a) The commissioner, through the organization under contract, shall  
139.10 award grants to hospitals, clinics, nursing facilities, assisted living facilities, and home care  
139.11 providers that agree to:

139.12 (1) provide secondary and postsecondary summer health care interns with formal exposure  
139.13 to the health care profession;

139.14 (2) provide an orientation for the secondary and postsecondary summer health care  
139.15 interns;

139.16 (3) pay one-half the costs of employing the secondary and postsecondary summer health  
139.17 care intern;

139.18 (4) interview and hire secondary and postsecondary pupils for a minimum of six weeks  
139.19 and a maximum of 12 weeks; and

139.20 (5) employ at least one secondary student for each postsecondary student employed, to  
139.21 the extent that there are sufficient qualifying secondary student applicants.

139.22 (b) In order to be eligible to be hired as a secondary summer health intern by a hospital,  
139.23 clinic, nursing facility, assisted living facility, or home care provider, a pupil must:

139.24 (1) intend to complete high school graduation requirements and be between the junior  
139.25 and senior year of high school; and

139.26 (2) be from a school district in proximity to the facility.

139.27 (c) In order to be eligible to be hired as a postsecondary summer health care intern by  
139.28 a hospital or clinic, a pupil must:

139.29 (1) intend to complete a health care training program or a two-year or four-year degree  
139.30 program and be planning on enrolling in or be enrolled in that training program or degree  
139.31 program; and

140.1 (2) be enrolled in a Minnesota educational institution or be a resident of the state of  
140.2 Minnesota; priority must be given to applicants from a school district or an educational  
140.3 institution in proximity to the facility.

140.4 (d) Hospitals, clinics, nursing facilities, assisted living facilities, and home care providers  
140.5 awarded grants may employ pupils as secondary and postsecondary summer health care  
140.6 interns beginning on or after June 15, 1993, if they agree to pay the intern, during the period

158.18 available appropriations, to hospitals, clinics, nursing facilities, assisted living facilities,  
158.19 and home care providers to establish a secondary and postsecondary summer health care  
158.20 intern program. The purpose of the program is to expose interested secondary and  
158.21 postsecondary pupils to various careers within the health care profession.

158.22 Sec. 15. Minnesota Statutes 2022, section 144.1464, subdivision 2, is amended to read:

158.23 Subd. 2. **Criteria.** (a) The commissioner, through the organization under contract, shall  
158.24 award grants to hospitals, clinics, nursing facilities, assisted living facilities, and home care  
158.25 providers that agree to:

158.26 (1) provide secondary and postsecondary summer health care interns with formal exposure  
158.27 to the health care profession;

158.28 (2) provide an orientation for the secondary and postsecondary summer health care  
158.29 interns;

158.30 (3) pay one-half the costs of employing the secondary and postsecondary summer health  
158.31 care intern;

159.1 (4) interview and hire secondary and postsecondary pupils for a minimum of six weeks  
159.2 and a maximum of 12 weeks; and

159.3 (5) employ at least one secondary student for each postsecondary student employed, to  
159.4 the extent that there are sufficient qualifying secondary student applicants.

159.5 (b) In order to be eligible to be hired as a secondary summer health intern by a hospital,  
159.6 clinic, nursing facility, assisted living facility, or home care provider, a pupil must:

159.7 (1) intend to complete high school graduation requirements and be between the junior  
159.8 and senior year of high school; and

159.9 (2) be from a school district in proximity to the facility.

159.10 (c) In order to be eligible to be hired as a postsecondary summer health care intern by  
159.11 a hospital or clinic, a pupil must:

159.12 (1) intend to complete a health care training program or a two-year or four-year degree  
159.13 program and be planning on enrolling in or be enrolled in that training program or degree  
159.14 program; and

159.15 (2) be enrolled in a Minnesota educational institution or be a resident of the state of  
159.16 Minnesota; priority must be given to applicants from a school district or an educational  
159.17 institution in proximity to the facility.

159.18 (d) Hospitals, clinics, nursing facilities, assisted living facilities, and home care providers  
159.19 awarded grants may employ pupils as secondary and postsecondary summer health care  
159.20 interns beginning on or after June 15, 1993, if they agree to pay the intern, during the period

140.7 before disbursement of state grant money, with money designated as the facility's 50 percent  
140.8 contribution towards internship costs.

140.9 Sec. 18. Minnesota Statutes 2022, section 144.1464, subdivision 3, is amended to read:

140.10 Subd. 3. **Grants.** The commissioner, through the organization under contract, shall  
140.11 award separate grants to hospitals, clinics, nursing facilities, and home care providers meeting  
140.12 the requirements of subdivision 2. The grants must be used to pay one-half of the costs of  
140.13 employing secondary and postsecondary pupils in a hospital, clinic, nursing facility, assisted  
140.14 living facilities, or home care setting during the course of the program. No more than 50  
140.15 percent of the participants may be postsecondary students, unless the program does not  
140.16 receive enough qualified secondary applicants per fiscal year. No more than five pupils may  
140.17 be selected from any secondary or postsecondary institution to participate in the program  
140.18 and no more than one-half of the number of pupils selected may be from the seven-county  
140.19 metropolitan area.

140.20 Sec. 19. Minnesota Statutes 2023 Supplement, section 144.1505, subdivision 2, is amended  
140.21 to read:

140.22 Subd. 2. **Programs.** (a) For advanced practice provider clinical training expansion grants,  
140.23 the commissioner of health shall award health professional training site grants to eligible  
140.24 physician assistant, advanced practice registered nurse, pharmacy, dental therapy, and mental  
140.25 health professional programs to plan and implement expanded clinical training. A planning  
140.26 grant shall not exceed \$75,000, and a three-year training grant shall not exceed ~~\$150,000~~  
140.27 ~~for the first year, \$100,000 for the second year, and \$50,000 for the third year~~ \$300,000 per  
140.28 ~~program project. The commissioner may provide a one-year, no-cost extension for grants.~~

140.29 (b) For health professional rural and underserved clinical rotations grants, the  
140.30 commissioner of health shall award health professional training site grants to eligible  
140.31 physician, physician assistant, advanced practice registered nurse, pharmacy, dentistry,  
140.32 dental therapy, and mental health professional programs to augment existing clinical training  
140.33 programs to add rural and underserved rotations or clinical training experiences, such as  
141.1 credential or certificate rural tracks or other specialized training. For physician and dentist  
141.2 training, the expanded training must include rotations in primary care settings such as  
141.3 community clinics, hospitals, health maintenance organizations, or practices in rural  
141.4 communities.

141.5 (c) Funds may be used for:

141.6 (1) establishing or expanding rotations and clinical training;

141.7 (2) recruitment, training, and retention of students and faculty;

141.8 (3) connecting students with appropriate clinical training sites, internships, practicums,  
141.9 or externship activities;

141.10 (4) travel and lodging for students;

159.21 before disbursement of state grant money, with money designated as the facility's 50 percent  
159.22 contribution towards internship costs.

159.23 Sec. 16. Minnesota Statutes 2022, section 144.1464, subdivision 3, is amended to read:

159.24 Subd. 3. **Grants.** The commissioner, through the organization under contract, shall  
159.25 award separate grants to hospitals, clinics, nursing facilities, assisted living facilities, and  
159.26 home care providers meeting the requirements of subdivision 2. The grants must be used  
159.27 to pay one-half of the costs of employing secondary and postsecondary pupils in a hospital,  
159.28 clinic, nursing facility, assisted living facility, or home care setting during the course of the  
159.29 program. No more than 50 percent of the participants may be postsecondary students, unless  
159.30 the program does not receive enough qualified secondary applicants per fiscal year. No  
159.31 more than five pupils may be selected from any secondary or postsecondary institution to  
160.1 participate in the program and no more than one-half of the number of pupils selected may  
160.2 be from the seven-county metropolitan area.

110.21 Sec. 7. Minnesota Statutes 2023 Supplement, section 144.1505, subdivision 2, is amended  
110.22 to read:

110.23 Subd. 2. **Programs.** (a) For advanced practice provider clinical training expansion grants,  
110.24 the commissioner of health shall award health professional training site grants to eligible  
110.25 physician assistant, advanced practice registered nurse, pharmacy, dental therapy, and mental  
110.26 health professional programs to plan and implement expanded clinical training. A planning  
110.27 grant shall not exceed \$75,000, and a three-year training grant shall not exceed ~~\$150,000~~  
110.28 ~~for the first year, \$100,000 for the second year, and \$50,000 for the third year~~ \$300,000 per  
110.29 ~~program project. The commissioner may provide a one-year, no-cost extension for grants.~~

110.30 (b) For health professional rural and underserved clinical rotations grants, the  
110.31 commissioner of health shall award health professional training site grants to eligible  
110.32 physician, physician assistant, advanced practice registered nurse, pharmacy, dentistry,  
110.33 dental therapy, and mental health professional programs to augment existing clinical training  
111.1 programs to add rural and underserved rotations or clinical training experiences, such as  
111.2 credential or certificate rural tracks or other specialized training. For physician and dentist  
111.3 training, the expanded training must include rotations in primary care settings such as  
111.4 community clinics, hospitals, health maintenance organizations, or practices in rural  
111.5 communities.

111.6 (c) Funds may be used for:

111.7 (1) establishing or expanding rotations and clinical training;

111.8 (2) recruitment, training, and retention of students and faculty;

111.9 (3) connecting students with appropriate clinical training sites, internships, practicums,  
111.10 or externship activities;

111.11 (4) travel and lodging for students;



141.11 (5) faculty, student, and preceptor salaries, incentives, or other financial support;  
141.12 (6) development and implementation of cultural competency training;  
141.13 (7) evaluations;  
141.14 (8) training site improvements, fees, equipment, and supplies required to establish,  
141.15 maintain, or expand a training program; and  
141.16 (9) supporting clinical education in which trainees are part of a primary care team model.  
141.17 Sec. 20. Minnesota Statutes 2022, section 144.1911, subdivision 2, is amended to read:  
141.18 Subd. 2. **Definitions.** (a) For the purposes of this section, the following terms have the  
141.19 meanings given.  
141.20 (b) "Commissioner" means the commissioner of health.  
141.21 (c) "Immigrant international medical graduate" means an international medical graduate  
141.22 who was born outside the United States, now resides permanently in the United States or  
141.23 who has entered the United States on a temporary status based on urgent humanitarian or  
141.24 significant public benefit reasons, and who did not enter the United States on a J1 or similar  
141.25 nonimmigrant visa following acceptance into a United States medical residency or fellowship  
141.26 program.  
141.27 (d) "International medical graduate" means a physician who received a basic medical  
141.28 degree or qualification from a medical school located outside the United States and Canada.  
141.29 (e) "Minnesota immigrant international medical graduate" means an immigrant  
141.30 international medical graduate who has lived in Minnesota for at least two years.  
142.1 (f) "Rural community" means a statutory and home rule charter city or township that is  
142.2 outside the seven-county metropolitan area as defined in section 473.121, subdivision 2,  
142.3 excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.  
142.4 (g) "Underserved community" means a Minnesota area or population included in the  
142.5 list of designated primary medical care health professional shortage areas, medically  
142.6 underserved areas, or medically underserved populations (MUPs) maintained and updated  
142.7 by the United States Department of Health and Human Services.  
  
142.8 Sec. 21. Minnesota Statutes 2022, section 144.212, is amended by adding a subdivision  
142.9 to read:  
142.10 Subd. 5a. **Replacement.** "Replacement" means a completion, addition, removal, or  
142.11 change made to certification items on a vital record after a vital event is registered and a  
142.12 record is established that has no notation of a change on a certificate and seals the prior vital  
142.13 record.

111.12 (5) faculty, student, and preceptor salaries, incentives, or other financial support;  
111.13 (6) development and implementation of cultural competency training;  
111.14 (7) evaluations;  
111.15 (8) training site improvements, fees, equipment, and supplies required to establish,  
111.16 maintain, or expand a training program; and  
111.17 (9) supporting clinical education in which trainees are part of a primary care team model.  
160.3 Sec. 17. Minnesota Statutes 2022, section 144.1911, subdivision 2, is amended to read:  
160.4 Subd. 2. **Definitions.** (a) For the purposes of this section, the following terms have the  
160.5 meanings given.  
160.6 (b) "Commissioner" means the commissioner of health.  
160.7 (c) "Immigrant international medical graduate" means an international medical graduate  
160.8 who was born outside the United States, now resides permanently in the United States or  
160.9 who has entered the United States on a temporary status based on urgent humanitarian or  
160.10 significant public benefit reasons, and who did not enter the United States on a J1 or similar  
160.11 nonimmigrant visa following acceptance into a United States medical residency or fellowship  
160.12 program.  
160.13 (d) "International medical graduate" means a physician who received a basic medical  
160.14 degree or qualification from a medical school located outside the United States and Canada.  
160.15 (e) "Minnesota immigrant international medical graduate" means an immigrant  
160.16 international medical graduate who has lived in Minnesota for at least two years.  
160.17 (f) "Rural community" means a statutory and home rule charter city or township that is  
160.18 outside the seven-county metropolitan area as defined in section 473.121, subdivision 2,  
160.19 excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.  
160.20 (g) "Underserved community" means a Minnesota area or population included in the  
160.21 list of designated primary medical care health professional shortage areas, medically  
160.22 underserved areas, or medically underserved populations (MUPs) maintained and updated  
160.23 by the United States Department of Health and Human Services.

FOR SECTIONS 18 TO 23, SEE ARTICLE 19, SECTIONS 7 TO 12

142.14 Sec. 22. Minnesota Statutes 2022, section 144.216, subdivision 2, is amended to read:

142.15 Subd. 2. **Status of foundling reports.** A report registered under subdivision 1 shall  
142.16 constitute the record of birth for the child. Information about the newborn shall be registered  
142.17 by the state registrar in accordance with Minnesota Rules, part 4601.0600, subpart 4, item  
142.18 C. If the child is identified and a record of birth is found or obtained, the report registered  
142.19 under subdivision 1 shall be confidential pursuant to section 13.02, subdivision 3, and shall  
142.20 not be disclosed except pursuant to court order.

142.21 Sec. 23. Minnesota Statutes 2022, section 144.216, is amended by adding a subdivision  
142.22 to read:

142.23 Subd. 3. **Reporting safe place newborns.** Hospitals that receive a newborn under section  
142.24 145.902 shall report the birth of the newborn to the Office of Vital Records within five days  
142.25 after receiving the newborn. Information about the newborn shall be registered by the state  
142.26 registrar in accordance with Minnesota Rules, part 4601.0600, subpart 4, item C.

142.27 Sec. 24. Minnesota Statutes 2022, section 144.216, is amended by adding a subdivision  
142.28 to read:

142.29 Subd. 4. **Status of safe place birth reports and registrations.** (a) Information about a  
142.30 safe place newborn registered under subdivision 3 shall constitute the record of birth for  
142.31 the child. The record shall be confidential pursuant to section 13.02, subdivision 3.  
143.1 Information on the birth record or a birth certificate issued from the birth record shall be  
143.2 disclosed only to the responsible social services agency or pursuant to a court order.

143.3 (b) Information about a safe place newborn registered under subdivision 3 shall constitute  
143.4 the record of birth for the child. If the safe place newborn was born in a hospital and it is  
143.5 known that a record of birth was registered, filed, or amended, the original birth record  
143.6 registered under section 144.215 shall be replaced pursuant to section 144.218, subdivision  
143.7 6.

143.8 Sec. 25. Minnesota Statutes 2022, section 144.218, is amended by adding a subdivision  
143.9 to read:

143.10 Subd. 6. **Safe place newborn; birth record.** If a safe place infant birth is registered  
143.11 pursuant to section 144.216, subdivision 4, paragraph (b), the state registrar shall issue a  
143.12 replacement birth record free of information that identifies a parent. The prior vital record  
143.13 shall be confidential pursuant to section 13.02, subdivision 3, and shall not be disclosed  
143.14 except pursuant to a court order.

143.15 Sec. 26. Minnesota Statutes 2022, section 144.493, is amended by adding a subdivision  
143.16 to read:

143.17 Subd. 2a. **Thrombectomy-capable stroke center.** A hospital meets the criteria for a  
143.18 thrombectomy-capable stroke center if the hospital has been certified as a  
143.19 thrombectomy-capable stroke center by the joint commission or another nationally recognized  
143.20 accreditation entity or is a primary stroke center that is not certified as a thrombectomy-based

163.26 Sec. 24. Minnesota Statutes 2022, section 144.493, is amended by adding a subdivision  
163.27 to read:

163.28 Subd. 2a. **Thrombectomy-capable stroke center.** A hospital meets the criteria for a  
163.29 thrombectomy-capable stroke center if the hospital has been certified as a  
164.1 thrombectomy-capable stroke center by the joint commission or another nationally recognized  
164.2 accreditation entity, or is a primary stroke center that is not certified as a thrombectomy-based

143.21 capable stroke center but the hospital has attained a level of stroke care distinction by offering  
143.22 mechanical endovascular therapies and has been certified by a department approved certifying  
143.23 body that is a nationally recognized guidelines-based organization.

143.24 Sec. 27. Minnesota Statutes 2022, section 144.494, subdivision 2, is amended to read:

143.25 Subd. 2. **Designation.** A hospital that voluntarily meets the criteria for a comprehensive  
143.26 stroke center, thrombectomy-capable stroke center, primary stroke center, or acute stroke  
143.27 ready hospital may apply to the commissioner for designation, and upon the commissioner's  
143.28 review and approval of the application, shall be designated as a comprehensive stroke center,  
143.29 a thrombectomy-capable stroke center, a primary stroke center, or an acute stroke ready  
143.30 hospital for a three-year period. If a hospital loses its certification as a comprehensive stroke  
143.31 center or primary stroke center from the joint commission or other nationally recognized  
143.32 accreditation entity, or no longer participates in the Minnesota stroke registry program, its  
144.1 Minnesota designation shall be immediately withdrawn. Prior to the expiration of the  
144.2 three-year designation period, a hospital seeking to remain part of the voluntary acute stroke  
144.3 system may reapply to the commissioner for designation.

144.4 Sec. 28. Minnesota Statutes 2022, section 144.551, subdivision 1, is amended to read:

144.5 Subdivision 1. **Restricted construction or modification.** (a) The following construction  
144.6 or modification may not be commenced:

144.7 (1) any erection, building, alteration, reconstruction, modernization, improvement,  
144.8 extension, lease, or other acquisition by or on behalf of a hospital that increases the bed  
144.9 capacity of a hospital, relocates hospital beds from one physical facility, complex, or site  
144.10 to another, or otherwise results in an increase or redistribution of hospital beds within the  
144.11 state; and

144.12 (2) the establishment of a new hospital.

144.13 (b) This section does not apply to:

144.14 (1) construction or relocation within a county by a hospital, clinic, or other health care  
144.15 facility that is a national referral center engaged in substantial programs of patient care,  
144.16 medical research, and medical education meeting state and national needs that receives more  
144.17 than 40 percent of its patients from outside the state of Minnesota;

144.18 (2) a project for construction or modification for which a health care facility held an  
144.19 approved certificate of need on May 1, 1984, regardless of the date of expiration of the  
144.20 certificate;

144.21 (3) a project for which a certificate of need was denied before July 1, 1990, if a timely  
144.22 appeal results in an order reversing the denial;

144.23 (4) a project exempted from certificate of need requirements by Laws 1981, chapter 200,  
144.24 section 2;

164.3 capable stroke center but the hospital has attained a level of stroke care distinction by offering  
164.4 mechanical endovascular therapies and has been certified by a department approved certifying  
164.5 body that is a nationally recognized guidelines-based organization.

164.6 Sec. 25. Minnesota Statutes 2022, section 144.494, subdivision 2, is amended to read:

164.7 Subd. 2. **Designation.** A hospital that voluntarily meets the criteria for a comprehensive  
164.8 stroke center, thrombectomy-capable stroke center, primary stroke center, or acute stroke  
164.9 ready hospital may apply to the commissioner for designation, and upon the commissioner's  
164.10 review and approval of the application, shall be designated as a comprehensive stroke center,  
164.11 a thrombectomy-capable stroke center, a primary stroke center, or an acute stroke ready  
164.12 hospital for a three-year period. If a hospital loses its certification as a comprehensive stroke  
164.13 center or primary stroke center from the joint commission or other nationally recognized  
164.14 accreditation entity, or no longer participates in the Minnesota stroke registry program, its  
164.15 Minnesota designation shall be immediately withdrawn. Prior to the expiration of the  
164.16 three-year designation period, a hospital seeking to remain part of the voluntary acute stroke  
164.17 system may reapply to the commissioner for designation.

164.18 Sec. 26. Minnesota Statutes 2022, section 144.551, subdivision 1, is amended to read:

164.19 Subdivision 1. **Restricted construction or modification.** (a) The following construction  
164.20 or modification may not be commenced:

164.21 (1) any erection, building, alteration, reconstruction, modernization, improvement,  
164.22 extension, lease, or other acquisition by or on behalf of a hospital that increases the bed  
164.23 capacity of a hospital, relocates hospital beds from one physical facility, complex, or site  
164.24 to another, or otherwise results in an increase or redistribution of hospital beds within the  
164.25 state; and

164.26 (2) the establishment of a new hospital.

164.27 (b) This section does not apply to:

164.28 (1) construction or relocation within a county by a hospital, clinic, or other health care  
164.29 facility that is a national referral center engaged in substantial programs of patient care,  
164.30 medical research, and medical education meeting state and national needs that receives more  
164.31 than 40 percent of its patients from outside the state of Minnesota;

165.1 (2) a project for construction or modification for which a health care facility held an  
165.2 approved certificate of need on May 1, 1984, regardless of the date of expiration of the  
165.3 certificate;

165.4 (3) a project for which a certificate of need was denied before July 1, 1990, if a timely  
165.5 appeal results in an order reversing the denial;

165.6 (4) a project exempted from certificate of need requirements by Laws 1981, chapter 200,  
165.7 section 2;

144.25 (5) a project involving consolidation of pediatric specialty hospital services within the  
144.26 Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number  
144.27 of pediatric specialty hospital beds among the hospitals being consolidated;

144.28 (6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to  
144.29 an existing licensed hospital that will allow for the reconstruction of a new philanthropic,  
144.30 pediatric-orthopedic hospital on an existing site and that will not result in a net increase in  
144.31 the number of hospital beds. Upon completion of the reconstruction, the licenses of both  
144.32 hospitals must be reinstated at the capacity that existed on each site before the relocation;

145.1 (7) the relocation or redistribution of hospital beds within a hospital building or  
145.2 identifiable complex of buildings provided the relocation or redistribution does not result  
145.3 in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from  
145.4 one physical site or complex to another; or (iii) redistribution of hospital beds within the  
145.5 state or a region of the state;

145.6 (8) relocation or redistribution of hospital beds within a hospital corporate system that  
145.7 involves the transfer of beds from a closed facility site or complex to an existing site or  
145.8 complex provided that: (i) no more than 50 percent of the capacity of the closed facility is  
145.9 transferred; (ii) the capacity of the site or complex to which the beds are transferred does  
145.10 not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal  
145.11 health systems agency boundary in place on July 1, 1983; (iv) the relocation or redistribution  
145.12 does not involve the construction of a new hospital building; and (v) the transferred beds  
145.13 are used first to replace within the hospital corporate system the total number of beds  
145.14 previously used in the closed facility site or complex for mental health services and substance  
145.15 use disorder services. Only after the hospital corporate system has fulfilled the requirements  
145.16 of this item may the remainder of the available capacity of the closed facility site or complex  
145.17 be transferred for any other purpose;

145.18 (9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice  
145.19 County that primarily serves adolescents and that receives more than 70 percent of its  
145.20 patients from outside the state of Minnesota;

145.21 (10) a project to replace a hospital or hospitals with a combined licensed capacity of  
145.22 130 beds or less if: (i) the new hospital site is located within five miles of the current site;  
145.23 and (ii) the total licensed capacity of the replacement hospital, either at the time of  
145.24 construction of the initial building or as the result of future expansion, will not exceed ~~70~~  
145.25 100 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever  
145.26 is less;

145.27 (11) the relocation of licensed hospital beds from an existing state facility operated by  
145.28 the commissioner of human services to a new or existing facility, building, or complex  
145.29 operated by the commissioner of human services; from one regional treatment center site  
145.30 to another; or from one building or site to a new or existing building or site on the same  
145.31 campus;

165.8 (5) a project involving consolidation of pediatric specialty hospital services within the  
165.9 Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number  
165.10 of pediatric specialty hospital beds among the hospitals being consolidated;

165.11 (6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to  
165.12 an existing licensed hospital that will allow for the reconstruction of a new philanthropic,  
165.13 pediatric-orthopedic hospital on an existing site and that will not result in a net increase in  
165.14 the number of hospital beds. Upon completion of the reconstruction, the licenses of both  
165.15 hospitals must be reinstated at the capacity that existed on each site before the relocation;

165.16 (7) the relocation or redistribution of hospital beds within a hospital building or  
165.17 identifiable complex of buildings provided the relocation or redistribution does not result  
165.18 in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from  
165.19 one physical site or complex to another; or (iii) redistribution of hospital beds within the  
165.20 state or a region of the state;

165.21 (8) relocation or redistribution of hospital beds within a hospital corporate system that  
165.22 involves the transfer of beds from a closed facility site or complex to an existing site or  
165.23 complex provided that: (i) no more than 50 percent of the capacity of the closed facility is  
165.24 transferred; (ii) the capacity of the site or complex to which the beds are transferred does  
165.25 not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal  
165.26 health systems agency boundary in place on July 1, 1983; (iv) the relocation or redistribution  
165.27 does not involve the construction of a new hospital building; and (v) the transferred beds  
165.28 are used first to replace within the hospital corporate system the total number of beds  
165.29 previously used in the closed facility site or complex for mental health services and substance  
165.30 use disorder services. Only after the hospital corporate system has fulfilled the requirements  
165.31 of this item may the remainder of the available capacity of the closed facility site or complex  
165.32 be transferred for any other purpose;

166.1 (9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice  
166.2 County that primarily serves adolescents and that receives more than 70 percent of its  
166.3 patients from outside the state of Minnesota;

166.4 (10) a project to replace a hospital or hospitals with a combined licensed capacity of  
166.5 130 beds or less if: (i) the new hospital site is located within five miles of the current site;  
166.6 and (ii) the total licensed capacity of the replacement hospital, either at the time of  
166.7 construction of the initial building or as the result of future expansion, will not exceed ~~70~~  
166.8 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

166.9 (11) the relocation of licensed hospital beds from an existing state facility operated by  
166.10 the commissioner of human services to a new or existing facility, building, or complex  
166.11 operated by the commissioner of human services; from one regional treatment center site  
166.12 to another; or from one building or site to a new or existing building or site on the same  
166.13 campus;

145.32 (12) the construction or relocation of hospital beds operated by a hospital having a  
145.33 statutory obligation to provide hospital and medical services for the indigent that does not  
145.34 result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27  
146.1 beds, of which 12 serve mental health needs, may be transferred from Hennepin County  
146.2 Medical Center to Regions Hospital under this clause;

146.3 (13) a construction project involving the addition of up to 31 new beds in an existing  
146.4 nonfederal hospital in Beltrami County;

146.5 (14) a construction project involving the addition of up to eight new beds in an existing  
146.6 nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

146.7 (15) a construction project involving the addition of 20 new hospital beds in an existing  
146.8 hospital in Carver County serving the southwest suburban metropolitan area;

146.9 (16) a project for the construction or relocation of up to 20 hospital beds for the operation  
146.10 of up to two psychiatric facilities or units for children provided that the operation of the  
146.11 facilities or units have received the approval of the commissioner of human services;

146.12 (17) a project involving the addition of 14 new hospital beds to be used for rehabilitation  
146.13 services in an existing hospital in Itasca County;

146.14 (18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County  
146.15 that closed 20 rehabilitation beds in 2002, provided that the beds are used only for  
146.16 rehabilitation in the hospital's current rehabilitation building. If the beds are used for another  
146.17 purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

146.18 (19) a critical access hospital established under section 144.1483, clause (9), and section  
146.19 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that  
146.20 delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33,  
146.21 to the extent that the critical access hospital does not seek to exceed the maximum number  
146.22 of beds permitted such hospital under federal law;

146.23 (20) notwithstanding section 144.552, a project for the construction of a new hospital  
146.24 in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

146.25 (i) the project, including each hospital or health system that will own or control the entity  
146.26 that will hold the new hospital license, is approved by a resolution of the Maple Grove City  
146.27 Council as of March 1, 2006;

146.28 (ii) the entity that will hold the new hospital license will be owned or controlled by one  
146.29 or more not-for-profit hospitals or health systems that have previously submitted a plan or  
146.30 plans for a project in Maple Grove as required under section 144.552, and the plan or plans  
146.31 have been found to be in the public interest by the commissioner of health as of April 1,  
146.32 2005;

147.1 (iii) the new hospital's initial inpatient services must include, but are not limited to,  
147.2 medical and surgical services, obstetrical and gynecological services, intensive care services,

166.14 (12) the construction or relocation of hospital beds operated by a hospital having a  
166.15 statutory obligation to provide hospital and medical services for the indigent that does not  
166.16 result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27  
166.17 beds, of which 12 serve mental health needs, may be transferred from Hennepin County  
166.18 Medical Center to Regions Hospital under this clause;

166.19 (13) a construction project involving the addition of up to 31 new beds in an existing  
166.20 nonfederal hospital in Beltrami County;

166.21 (14) a construction project involving the addition of up to eight new beds in an existing  
166.22 nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

166.23 (15) a construction project involving the addition of 20 new hospital beds in an existing  
166.24 hospital in Carver County serving the southwest suburban metropolitan area;

166.25 (16) a project for the construction or relocation of up to 20 hospital beds for the operation  
166.26 of up to two psychiatric facilities or units for children provided that the operation of the  
166.27 facilities or units have received the approval of the commissioner of human services;

166.28 (17) a project involving the addition of 14 new hospital beds to be used for rehabilitation  
166.29 services in an existing hospital in Itasca County;

166.30 (18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County  
166.31 that closed 20 rehabilitation beds in 2002, provided that the beds are used only for  
166.32 rehabilitation in the hospital's current rehabilitation building. If the beds are used for another  
166.33 purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

167.1 (19) a critical access hospital established under section 144.1483, clause (9), and section  
167.2 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that  
167.3 delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33,  
167.4 to the extent that the critical access hospital does not seek to exceed the maximum number  
167.5 of beds permitted such hospital under federal law;

167.6 (20) notwithstanding section 144.552, a project for the construction of a new hospital  
167.7 in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

167.8 (i) the project, including each hospital or health system that will own or control the entity  
167.9 that will hold the new hospital license, is approved by a resolution of the Maple Grove City  
167.10 Council as of March 1, 2006;

167.11 (ii) the entity that will hold the new hospital license will be owned or controlled by one  
167.12 or more not-for-profit hospitals or health systems that have previously submitted a plan or  
167.13 plans for a project in Maple Grove as required under section 144.552, and the plan or plans  
167.14 have been found to be in the public interest by the commissioner of health as of April 1,  
167.15 2005;

167.16 (iii) the new hospital's initial inpatient services must include, but are not limited to,  
167.17 medical and surgical services, obstetrical and gynecological services, intensive care services,

147.3 orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health  
147.4 services, and emergency room services;

147.5 (iv) the new hospital:

147.6 (A) will have the ability to provide and staff sufficient new beds to meet the growing  
147.7 needs of the Maple Grove service area and the surrounding communities currently being  
147.8 served by the hospital or health system that will own or control the entity that will hold the  
147.9 new hospital license;

147.10 (B) will provide uncompensated care;

147.11 (C) will provide mental health services, including inpatient beds;

147.12 (D) will be a site for workforce development for a broad spectrum of health-care-related  
147.13 occupations and have a commitment to providing clinical training programs for physicians  
147.14 and other health care providers;

147.15 (E) will demonstrate a commitment to quality care and patient safety;

147.16 (F) will have an electronic medical records system, including physician order entry;

147.17 (G) will provide a broad range of senior services;

147.18 (H) will provide emergency medical services that will coordinate care with regional  
147.19 providers of trauma services and licensed emergency ambulance services in order to enhance  
147.20 the continuity of care for emergency medical patients; and

147.21 (I) will be completed by December 31, 2009, unless delayed by circumstances beyond  
147.22 the control of the entity holding the new hospital license; and

147.23 (v) as of 30 days following submission of a written plan, the commissioner of health  
147.24 has not determined that the hospitals or health systems that will own or control the entity  
147.25 that will hold the new hospital license are unable to meet the criteria of this clause;

147.26 (21) a project approved under section 144.553;

147.27 (22) a project for the construction of a hospital with up to 25 beds in Cass County within  
147.28 a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder  
147.29 is approved by the Cass County Board;

148.1 (23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity  
148.2 from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing  
148.3 a separately licensed 13-bed skilled nursing facility;

148.4 (24) notwithstanding section 144.552, a project for the construction and expansion of a  
148.5 specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients  
148.6 who are under 21 years of age on the date of admission. The commissioner conducted a  
148.7 public interest review of the mental health needs of Minnesota and the Twin Cities

167.18 orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health  
167.19 services, and emergency room services;

167.20 (iv) the new hospital:

167.21 (A) will have the ability to provide and staff sufficient new beds to meet the growing  
167.22 needs of the Maple Grove service area and the surrounding communities currently being  
167.23 served by the hospital or health system that will own or control the entity that will hold the  
167.24 new hospital license;

167.25 (B) will provide uncompensated care;

167.26 (C) will provide mental health services, including inpatient beds;

167.27 (D) will be a site for workforce development for a broad spectrum of health-care-related  
167.28 occupations and have a commitment to providing clinical training programs for physicians  
167.29 and other health care providers;

167.30 (E) will demonstrate a commitment to quality care and patient safety;

167.31 (F) will have an electronic medical records system, including physician order entry;

167.32 (G) will provide a broad range of senior services;

168.1 (H) will provide emergency medical services that will coordinate care with regional  
168.2 providers of trauma services and licensed emergency ambulance services in order to enhance  
168.3 the continuity of care for emergency medical patients; and

168.4 (I) will be completed by December 31, 2009, unless delayed by circumstances beyond  
168.5 the control of the entity holding the new hospital license; and

168.6 (v) as of 30 days following submission of a written plan, the commissioner of health  
168.7 has not determined that the hospitals or health systems that will own or control the entity  
168.8 that will hold the new hospital license are unable to meet the criteria of this clause;

168.9 (21) a project approved under section 144.553;

168.10 (22) a project for the construction of a hospital with up to 25 beds in Cass County within  
168.11 a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder  
168.12 is approved by the Cass County Board;

168.13 (23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity  
168.14 from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing  
168.15 a separately licensed 13-bed skilled nursing facility;

168.16 (24) notwithstanding section 144.552, a project for the construction and expansion of a  
168.17 specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients  
168.18 who are under 21 years of age on the date of admission. The commissioner conducted a  
168.19 public interest review of the mental health needs of Minnesota and the Twin Cities

148.8 metropolitan area in 2008. No further public interest review shall be conducted for the  
148.9 construction or expansion project under this clause;

148.10 (25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the  
148.11 commissioner finds the project is in the public interest after the public interest review  
148.12 conducted under section 144.552 is complete;

148.13 (26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city  
148.14 of Maple Grove, exclusively for patients who are under 21 years of age on the date of  
148.15 admission, if the commissioner finds the project is in the public interest after the public  
148.16 interest review conducted under section 144.552 is complete;

148.17 (ii) this project shall serve patients in the continuing care benefit program under section  
148.18 256.9693. The project may also serve patients not in the continuing care benefit program;  
148.19 and

148.20 (iii) if the project ceases to participate in the continuing care benefit program, the  
148.21 commissioner must complete a subsequent public interest review under section 144.552. If  
148.22 the project is found not to be in the public interest, the license must be terminated six months  
148.23 from the date of that finding. If the commissioner of human services terminates the contract  
148.24 without cause or reduces per diem payment rates for patients under the continuing care  
148.25 benefit program below the rates in effect for services provided on December 31, 2015, the  
148.26 project may cease to participate in the continuing care benefit program and continue to  
148.27 operate without a subsequent public interest review;

148.28 (27) a project involving the addition of 21 new beds in an existing psychiatric hospital  
148.29 in Hennepin County that is exclusively for patients who are under 21 years of age on the  
148.30 date of admission;

148.31 (28) a project to add 55 licensed beds in an existing safety net, level I trauma center  
148.32 hospital in Ramsey County as designated under section 383A.91, subdivision 5, of which  
148.33 15 beds are to be used for inpatient mental health and 40 are to be used for other services.  
148.34 In addition, five unlicensed observation mental health beds shall be added;

149.1 (29) upon submission of a plan to the commissioner for public interest review under  
149.2 section 144.552 and the addition of the 15 inpatient mental health beds specified in clause  
149.3 (28), to its bed capacity, a project to add 45 licensed beds in an existing safety net, level I  
149.4 trauma center hospital in Ramsey County as designated under section 383A.91, subdivision  
149.5 5. Five of the 45 additional beds authorized under this clause must be designated for use  
149.6 for inpatient mental health and must be added to the hospital's bed capacity before the  
149.7 remaining 40 beds are added. Notwithstanding section 144.552, the hospital may add licensed  
149.8 beds under this clause prior to completion of the public interest review, provided the hospital  
149.9 submits its plan by the 2021 deadline and adheres to the timelines for the public interest  
149.10 review described in section 144.552;

149.11 (30) upon submission of a plan to the commissioner for public interest review under  
149.12 section 144.552, a project to add up to 30 licensed beds in an existing psychiatric hospital

168.20 metropolitan area in 2008. No further public interest review shall be conducted for the  
168.21 construction or expansion project under this clause;

168.22 (25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the  
168.23 commissioner finds the project is in the public interest after the public interest review  
168.24 conducted under section 144.552 is complete;

168.25 (26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city  
168.26 of Maple Grove, exclusively for patients who are under 21 years of age on the date of  
168.27 admission, if the commissioner finds the project is in the public interest after the public  
168.28 interest review conducted under section 144.552 is complete;

168.29 (ii) this project shall serve patients in the continuing care benefit program under section  
168.30 256.9693. The project may also serve patients not in the continuing care benefit program;  
168.31 and

168.32 (iii) if the project ceases to participate in the continuing care benefit program, the  
168.33 commissioner must complete a subsequent public interest review under section 144.552. If  
169.1 the project is found not to be in the public interest, the license must be terminated six months  
169.2 from the date of that finding. If the commissioner of human services terminates the contract  
169.3 without cause or reduces per diem payment rates for patients under the continuing care  
169.4 benefit program below the rates in effect for services provided on December 31, 2015, the  
169.5 project may cease to participate in the continuing care benefit program and continue to  
169.6 operate without a subsequent public interest review;

169.7 (27) a project involving the addition of 21 new beds in an existing psychiatric hospital  
169.8 in Hennepin County that is exclusively for patients who are under 21 years of age on the  
169.9 date of admission;

169.10 (28) a project to add 55 licensed beds in an existing safety net, level I trauma center  
169.11 hospital in Ramsey County as designated under section 383A.91, subdivision 5, of which  
169.12 15 beds are to be used for inpatient mental health and 40 are to be used for other services.  
169.13 In addition, five unlicensed observation mental health beds shall be added;

169.14 (29) upon submission of a plan to the commissioner for public interest review under  
169.15 section 144.552 and the addition of the 15 inpatient mental health beds specified in clause  
169.16 (28), to its bed capacity, a project to add 45 licensed beds in an existing safety net, level I  
169.17 trauma center hospital in Ramsey County as designated under section 383A.91, subdivision  
169.18 5. Five of the 45 additional beds authorized under this clause must be designated for use  
169.19 for inpatient mental health and must be added to the hospital's bed capacity before the  
169.20 remaining 40 beds are added. Notwithstanding section 144.552, the hospital may add licensed  
169.21 beds under this clause prior to completion of the public interest review, provided the hospital  
169.22 submits its plan by the 2021 deadline and adheres to the timelines for the public interest  
169.23 review described in section 144.552;

169.24 (30) upon submission of a plan to the commissioner for public interest review under  
169.25 section 144.552, a project to add up to 30 licensed beds in an existing psychiatric hospital

149.13 in Hennepin County that exclusively provides care to patients who are under 21 years of  
149.14 age on the date of admission. Notwithstanding section 144.552, the psychiatric hospital  
149.15 may add licensed beds under this clause prior to completion of the public interest review,  
149.16 provided the hospital submits its plan by the 2021 deadline and adheres to the timelines for  
149.17 the public interest review described in section 144.552;

149.18 (31) any project to add licensed beds in a hospital located in Cook County or Mahanomen  
149.19 County that: (i) is designated as a critical access hospital under section 144.1483, clause  
149.20 (9), and United States Code, title 42, section 1395i-4; (ii) has a licensed bed capacity of  
149.21 fewer than 25 beds; and (iii) has an attached nursing home, so long as the total number of  
149.22 licensed beds in the hospital after the bed addition does not exceed 25 beds. Notwithstanding  
149.23 section 144.552, a public interest review is not required for a project authorized under this  
149.24 clause;

149.25 (32) upon submission of a plan to the commissioner for public interest review under  
149.26 section 144.552, a project to add 22 licensed beds at a Minnesota freestanding children's  
149.27 hospital in St. Paul that is part of an independent pediatric health system with freestanding  
149.28 inpatient hospitals located in Minneapolis and St. Paul. The beds shall be utilized for pediatric  
149.29 inpatient behavioral health services. Notwithstanding section 144.552, the hospital may add  
149.30 licensed beds under this clause prior to completion of the public interest review, provided  
149.31 the hospital submits its plan by the 2022 deadline and adheres to the timelines for the public  
149.32 interest review described in section 144.552; ~~or~~

149.33 (33) a project for a 144-bed psychiatric hospital on the site of the former Bethesda  
149.34 hospital in the city of Saint Paul, Ramsey County, if the commissioner finds the project is  
149.35 in the public interest after the public interest review conducted under section 144.552 is  
150.1 complete. Following the completion of the construction project, the commissioner of health  
150.2 shall monitor the hospital, including by assessing the hospital's case mix and payer mix,  
150.3 patient transfers, and patient diversions. The hospital must have an intake and assessment  
150.4 area. The hospital must accommodate patients with acute mental health needs, whether they  
150.5 walk up to the facility, are delivered by ambulances or law enforcement, or are transferred  
150.6 from other facilities. The hospital must comply with subdivision 1a, paragraph (b). The  
150.7 hospital must annually submit de-identified data to the department in the format and manner  
150.8 defined by the commissioner; or

150.9 (34) a project involving the relocation of up to 26 licensed long-term acute care hospital  
150.10 beds from an existing long-term care hospital located in Hennepin County with a licensed  
150.11 capacity prior to the relocation of 92 beds to dedicated space on the campus of an existing  
150.12 safety net, level I trauma center hospital in Ramsey County as designated under section  
150.13 383A.91, subdivision 5, provided both the commissioner finds the project is in the public  
150.14 interest after the public interest review conducted under section 144.552 is complete and  
150.15 the relocated beds continue to be used as long-term acute care hospital beds after the  
150.16 relocation.

169.26 in Hennepin County that exclusively provides care to patients who are under 21 years of  
169.27 age on the date of admission. Notwithstanding section 144.552, the psychiatric hospital  
169.28 may add licensed beds under this clause prior to completion of the public interest review,  
169.29 provided the hospital submits its plan by the 2021 deadline and adheres to the timelines for  
169.30 the public interest review described in section 144.552;

169.31 (31) any project to add licensed beds in a hospital located in Cook County or Mahanomen  
169.32 County that: (i) is designated as a critical access hospital under section 144.1483, clause  
169.33 (9), and United States Code, title 42, section 1395i-4; (ii) has a licensed bed capacity of  
169.34 fewer than 25 beds; and (iii) has an attached nursing home, so long as the total number of  
170.1 licensed beds in the hospital after the bed addition does not exceed 25 beds. Notwithstanding  
170.2 section 144.552, a public interest review is not required for a project authorized under this  
170.3 clause;

170.4 (32) upon submission of a plan to the commissioner for public interest review under  
170.5 section 144.552, a project to add 22 licensed beds at a Minnesota freestanding children's  
170.6 hospital in St. Paul that is part of an independent pediatric health system with freestanding  
170.7 inpatient hospitals located in Minneapolis and St. Paul. The beds shall be utilized for pediatric  
170.8 inpatient behavioral health services. Notwithstanding section 144.552, the hospital may add  
170.9 licensed beds under this clause prior to completion of the public interest review, provided  
170.10 the hospital submits its plan by the 2022 deadline and adheres to the timelines for the public  
170.11 interest review described in section 144.552; ~~or~~

170.12 (33) a project for a 144-bed psychiatric hospital on the site of the former Bethesda  
170.13 hospital in the city of Saint Paul, Ramsey County, if the commissioner finds the project is  
170.14 in the public interest after the public interest review conducted under section 144.552 is  
170.15 complete. Following the completion of the construction project, the commissioner of health  
170.16 shall monitor the hospital, including by assessing the hospital's case mix and payer mix,  
170.17 patient transfers, and patient diversions. The hospital must have an intake and assessment  
170.18 area. The hospital must accommodate patients with acute mental health needs, whether they  
170.19 walk up to the facility, are delivered by ambulances or law enforcement, or are transferred  
170.20 from other facilities. The hospital must comply with subdivision 1a, paragraph (b). The  
170.21 hospital must annually submit de-identified data to the department in the format and manner  
170.22 defined by the commissioner; or

170.23 (34) a project involving the relocation of up to 26 licensed long-term acute care hospital  
170.24 beds from an existing long-term care hospital located in Hennepin County with a licensed  
170.25 capacity prior to the relocation of 92 beds to dedicated space on the campus of an existing  
170.26 safety net, level I trauma center hospital in Ramsey County as designated under section  
170.27 383A.91, subdivision 5, provided both the commissioner finds the project is in the public  
170.28 interest after the public interest review conducted under section 144.552 is complete and  
170.29 the relocated beds continue to be used as long-term acute care hospital beds after the  
170.30 relocation.



150.17 Sec. 29. Minnesota Statutes 2022, section 144.605, is amended by adding a subdivision  
150.18 to read:

150.19 Subd. 10. Chapter 16C waiver. Pursuant to subdivisions 4, paragraph (b), and 5,  
150.20 paragraph (b), the commissioner of administration may waive provisions of chapter 16C  
150.21 for the purposes of approving contracts for independent clinical teams.

171.1 Sec. 27. Minnesota Statutes 2022, section 144.605, is amended by adding a subdivision  
171.2 to read:

171.3 Subd. 10. Chapter 16C waiver. Pursuant to subdivisions 4, paragraph (b), and 5,  
171.4 paragraph (b), the commissioner of administration may waive provisions of chapter 16C  
171.5 for the purposes of approving contracts for independent clinical teams.

171.6 Sec. 28. Minnesota Statutes 2023 Supplement, section 144.651, subdivision 10a, is amended  
171.7 to read:

171.8 Subd. 10a. Designated support person for pregnant patient or other patient. (a)  
171.9 Subject to paragraph (c), a health care provider and a health care facility must allow, at a  
171.10 minimum, one designated support person of a pregnant patient's choosing chosen by a  
171.11 patient, including but not limited to a pregnant patient, to be physically present while the  
171.12 patient is receiving health care services including during a hospital stay.

171.13 (b) For purposes of this subdivision, "designated support person" means any person  
171.14 chosen by the patient to provide comfort to the patient including but not limited to the  
171.15 patient's spouse, partner, family member, or another person related by affinity. Certified  
171.16 doulas and traditional midwives may not be counted toward the limit of one designated  
171.17 support person.

171.18 (c) A facility may restrict or prohibit the presence of a designated support person in  
171.19 treatment rooms, procedure rooms, and operating rooms when such a restriction or prohibition  
171.20 is strictly necessary to meet the appropriate standard of care. A facility may also restrict or  
171.21 prohibit the presence of a designated support person if the designated support person is  
171.22 acting in a violent or threatening manner toward others. Any restriction or prohibition of a  
171.23 designated support person by the facility is subject to the facility's written internal grievance  
171.24 procedure required by subdivision 20.

171.25 Sec. 29. [144.6985] COMMUNITY HEALTH NEEDS ASSESSMENT; COMMUNITY  
171.26 HEALTH IMPROVEMENT SERVICES; IMPLEMENTATION.

171.27 Subdivision 1. Community health needs assessment. A nonprofit hospital that is exempt  
171.28 from taxation under section 501(c)(3) of the Internal Revenue Code must make available  
171.29 to the public and submit to the commissioner of health, by January 15, 2026, the most recent  
171.30 community health needs assessment submitted by the hospital to the Internal Revenue  
171.31 Service. Each time the hospital conducts a subsequent community health needs assessment,  
171.32 the hospital must, within 15 business days after submitting the subsequent community health  
172.1 needs assessment to the Internal Revenue Service, make the subsequent assessment available  
172.2 to the public and submit the subsequent assessment to the commissioner.

172.3 Subd. 2. Description of community. A nonprofit hospital subject to subdivision 1 must  
172.4 make available to the public and submit to the commissioner of health a description of the  
172.5 community served by the hospital. The description must include a geographic description  
172.6 of the area where the hospital is located, a description of the general population served by  
172.7 the hospital, and demographic information about the community served by the hospital.

172.8 such as leading causes of death, levels of chronic illness, and descriptions of the medically  
172.9 underserved, low-income, minority, or chronically ill populations in the community. A  
172.10 hospital is not required to separately make the information available to the public or  
172.11 separately submit the information to the commissioner if the information is included in the  
172.12 hospital's community health needs assessment made available and submitted under  
172.13 subdivision 1.

172.14 Subd. 3. **Addendum; community health improvement services.** (a) A nonprofit hospital  
172.15 subject to subdivision 1 must annually submit to the commissioner an addendum which  
172.16 details information about hospital activities identified as community health improvement  
172.17 services with a cost of \$5,000 or more. The addendum must include the type of activity, the  
172.18 method through which the activity was delivered, how the activity relates to an identified  
172.19 community need in the community health needs assessment, the target population for the  
172.20 activity, strategies to reach the target population, identified outcome metrics, the cost to the  
172.21 hospital to provide the activity, the methodology used to calculate the hospital's costs, and  
172.22 the number of people served by the activity. If a community health improvement service is  
172.23 administered by an entity other than the hospital, the administering entity must be identified  
172.24 in the addendum. This paragraph does not apply to hospitals required to submit an addendum  
172.25 under paragraph (b).

172.26 (b) A nonprofit hospital subject to subdivision 1 must annually submit to the  
172.27 commissioner an addendum which details information about the ten highest-cost activities  
172.28 of the hospital identified as community health improvement services if the nonprofit hospital:

172.29 (1) is designated as a critical access hospital under section 144.1483, clause (9), and  
172.30 United States Code, title 42, section 1395i-4;

172.31 (2) meets the definition of sole community hospital in section 62Q.19, subdivision 1,  
172.32 paragraph (a), clause (5); or

172.33 (3) meets the definition of rural emergency hospital in United States Code, title 42,  
172.34 section 1395x(kkk)(2).

173.1 The addendum must include the type of activity, the method in which the activity was  
173.2 delivered, how the activity relates to an identified community need in the community health  
173.3 needs assessment, the target population for the activity, strategies to reach the target  
173.4 population, identified outcome metrics, the cost to the hospital to provide the activity, the  
173.5 methodology used to calculate the hospital's costs, and the number of people served by the  
173.6 activity. If a community health improvement service is administered by an entity other than  
173.7 the hospital, the administering entity must be identified in the addendum.

173.8 Subd. 4. **Community benefit implementation strategy.** A nonprofit hospital subject  
173.9 to subdivision 1 must make available to the public, within one year after completing each  
173.10 community health needs assessment, a community benefit implementation strategy. In  
173.11 developing the community benefit implementation strategy, the hospital must consult with  
173.12 community-based organizations, stakeholders, local public health organizations, and others

150.22 Sec. 30. Minnesota Statutes 2022, section 144.99, subdivision 3, is amended to read:

150.23 Subd. 3. **Correction orders.** (a) The commissioner may issue correction orders that  
150.24 require a person to correct a violation of the statutes, rules, and other actions listed in  
150.25 subdivision 1. The correction order must state the deficiencies that constitute the violation;  
150.26 the specific statute, rule, or other action; and the time by which the violation must be  
150.27 corrected.

150.28 (b) If the person believes that the information contained in the commissioner's correction  
150.29 order is in error, the person may ask the commissioner to reconsider the parts of the order

173.13 as determined by the hospital. The implementation strategy must include how the hospital  
173.14 shall address the top three community health priorities identified in the community health  
173.15 needs assessment. Implementation strategies must be evidence-based, when available, and  
173.16 development and implementation of innovative programs and strategies may be supported  
173.17 by evaluation measures.

173.18 Subd. 5. **Information made available to the public.** A nonprofit hospital required to  
173.19 make information available to the public under this section may do so by posting the  
173.20 information on the hospital's website in a consolidated location and with clear labeling.

173.21 **EFFECTIVE DATE.** This section is effective January 1, 2026.

173.22 Sec. 30. Minnesota Statutes 2022, section 144.7067, subdivision 2, is amended to read:

173.23 Subd. 2. **Duty to analyze reports; communicate findings.** (a) The commissioner shall:

173.24 (1) analyze adverse event reports, corrective action plans, and findings of the root cause  
173.25 analyses to determine patterns of systemic failure in the health care system and successful  
173.26 methods to correct these failures;

173.27 (2) communicate to individual facilities the commissioner's conclusions, if any, regarding  
173.28 an adverse event reported by the facility;

173.29 (3) communicate with relevant health care facilities any recommendations for corrective  
173.30 action resulting from the commissioner's analysis of submissions from facilities; and

173.31 (4) publish an annual report:

173.32 (i) describing, by institution, adverse events reported;

174.1 (ii) outlining, in aggregate, corrective action plans and the findings of root cause analyses;  
174.2 and

174.3 (iii) making recommendations for modifications of state health care operations.

174.4 (b) Notwithstanding section 144.05, subdivision 7, the mandate to publish an annual  
174.5 report under this subdivision does not expire.

174.6 **EFFECTIVE DATE.** This section is effective retroactively from January 1, 2023.

150.30 that are alleged to be in error. The request must be in writing, delivered to the commissioner  
150.31 by certified mail within ~~seven~~ 15 calendar days after receipt of the order, and:

150.32 (1) specify which parts of the order for corrective action are alleged to be in error;

151.1 (2) explain why they are in error; and

151.2 (3) provide documentation to support the allegation of error.

151.3 The commissioner must respond to requests made under this paragraph within 15 calendar  
151.4 days after receiving a request. A request for reconsideration does not stay the correction  
151.5 order; however, after reviewing the request for reconsideration, the commissioner may  
151.6 provide additional time to comply with the order if necessary. The commissioner's disposition  
151.7 of a request for reconsideration is final.

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

151.9 Sec. 31. Minnesota Statutes 2022, section 144A.10, subdivision 15, is amended to read:

151.10 Subd. 15. **Informal dispute resolution.** The commissioner shall respond in writing to  
151.11 a request from a nursing facility certified under the federal Medicare and Medicaid programs  
151.12 for an informal dispute resolution within ~~30 days of the exit date of the facility's survey~~ ten  
151.13 calendar days of the facility's receipt of the notice of deficiencies. The commissioner's  
151.14 response shall identify the commissioner's decision regarding ~~the continuation of each~~  
151.15 deficiency citation challenged by the nursing facility, as well as a statement of any changes  
151.16 in findings, level of severity or scope, and proposed remedies or sanctions for each deficiency  
151.17 citation.

151.18 **EFFECTIVE DATE.** This section is effective August 1, 2024.

151.19 Sec. 32. Minnesota Statutes 2022, section 144A.10, subdivision 16, is amended to read:

151.20 Subd. 16. **Independent informal dispute resolution.** (a) Notwithstanding subdivision  
151.21 15, a facility certified under the federal Medicare or Medicaid programs that has been  
151.22 assessed a civil money penalty as provided by Code of Federal Regulations, title 42, section  
151.23 488.430, may request from the commissioner, in writing, an independent informal dispute  
151.24 resolution process regarding any deficiency ~~citation issued to the facility~~. The facility must  
151.25 ~~specify in its written request each deficiency citation that it disputes. The commissioner~~  
151.26 ~~shall provide a hearing under sections 14.57 to 14.62. Upon the written request of the facility,~~  
151.27 ~~the parties must submit the issues raised to arbitration by an administrative law judge submit~~  
151.28 ~~its request in writing within ten calendar days of receiving notice that a civil money penalty~~  
151.29 ~~will be imposed.~~

151.30 (b) The facility and commissioner have the right to be represented by an attorney at the  
151.31 hearing.

152.1 (c) An independent informal dispute resolution may not be requested for any deficiency  
152.2 that is the subject of an active informal dispute resolution requested under subdivision 15.

174.7 Sec. 31. Minnesota Statutes 2022, section 144A.10, subdivision 15, is amended to read:

174.8 Subd. 15. **Informal dispute resolution.** The commissioner shall respond in writing to  
174.9 a request from a nursing facility certified under the federal Medicare and Medicaid programs  
174.10 for an informal dispute resolution within ~~30 days of the exit date of the facility's survey~~ ten  
174.11 calendar days of the facility's receipt of the notice of deficiencies. The commissioner's  
174.12 response shall identify the commissioner's decision regarding ~~the continuation of each~~  
174.13 deficiency citation challenged by the nursing facility, as well as a statement of any changes  
174.14 in findings, level of severity or scope, and proposed remedies or sanctions for each deficiency  
174.15 citation.

174.16 **EFFECTIVE DATE.** This section is effective August 1, 2024.

174.17 Sec. 32. Minnesota Statutes 2022, section 144A.10, subdivision 16, is amended to read:

174.18 Subd. 16. **Independent informal dispute resolution.** (a) Notwithstanding subdivision  
174.19 15, a facility certified under the federal Medicare or Medicaid programs that has been  
174.20 assessed a civil money penalty as provided by Code of Federal Regulations, title 42, section  
174.21 488.430, may request from the commissioner, in writing, an independent informal dispute  
174.22 resolution process regarding any deficiency ~~citation issued to the facility~~. The facility must  
174.23 ~~specify in its written request each deficiency citation that it disputes. The commissioner~~  
174.24 ~~shall provide a hearing under sections 14.57 to 14.62. Upon the written request of the facility,~~  
174.25 ~~the parties must submit the issues raised to arbitration by an administrative law judge submit~~  
174.26 ~~its request in writing within ten calendar days of receiving notice that a civil money penalty~~  
174.27 ~~will be imposed.~~

174.28 (b) The facility and commissioner have the right to be represented by an attorney at the  
174.29 hearing.

174.30 (c) An independent informal dispute resolution may not be requested for any deficiency  
174.31 that is the subject of an active informal dispute resolution requested under subdivision 15.

152.3 The facility must withdraw its informal dispute resolution prior to requesting independent  
152.4 informal dispute resolution.

152.5 ~~(b) Upon~~ (d) Within five calendar days of receipt of a written request for an ~~arbitration~~  
152.6 ~~proceeding independent informal dispute resolution~~, the commissioner shall file with the  
152.7 Office of Administrative Hearings a request for the appointment of an ~~arbitrator~~  
152.8 administrative law judge from the Office of Administrative Hearings and simultaneously  
152.9 serve the facility with notice of the request. ~~The arbitrator for the dispute shall be an~~  
152.10 ~~administrative law judge appointed by the Office of Administrative Hearings. The disclosure~~  
152.11 ~~provisions of section 572B.12 and the notice provisions of section 572B.15, subsection (e),~~  
152.12 ~~apply. The facility and the commissioner have the right to be represented by an attorney.~~

152.13 (e) An independent informal dispute resolution proceeding shall be scheduled to occur  
152.14 within 30 calendar days of the commissioner's request to the Office of Administrative  
152.15 Hearings, unless the parties agree otherwise or the chief administrative law judge deems  
152.16 the timing to be unreasonable. The independent informal dispute resolution process must  
152.17 be completed within 60 calendar days of the facility's request.

152.18 ~~(e)~~ (f) Five working days in advance of the scheduled proceeding, the commissioner  
152.19 and the facility ~~may present~~ must submit written statements and arguments, documentary  
152.20 evidence, depositions, and ~~oral statements and arguments at the arbitration proceeding. Oral~~  
152.21 ~~statements and arguments may be made by telephone~~ any other materials supporting their  
152.22 position to the administrative law judge.

152.23 (g) The independent informal dispute resolution proceeding shall be informal and  
152.24 conducted in a manner so as to allow the parties to fully present their positions and respond  
152.25 to the opposing party's positions. This may include presentation of oral statements and  
152.26 arguments at the proceeding.

152.27 ~~(d)~~ (h) Within ten working days of the close of the ~~arbitration~~ proceeding, the  
152.28 administrative law judge shall issue findings and recommendations regarding each of the  
152.29 deficiencies in dispute. The findings shall be one or more of the following:

152.30 (1) Supported in full. The citation is supported in full, with no deletion of findings and  
152.31 no change in the scope or severity assigned to the deficiency citation.

152.32 (2) Supported in substance. The citation is supported, but one or more findings are  
152.33 deleted without any change in the scope or severity assigned to the deficiency.

153.1 (3) Deficient practice cited under wrong requirement of participation. The citation is  
153.2 amended by moving it to the correct requirement of participation.

153.3 (4) Scope not supported. The citation is amended through a change in the scope assigned  
153.4 to the citation.

153.5 (5) Severity not supported. The citation is amended through a change in the severity  
153.6 assigned to the citation.

175.1 The facility must withdraw its informal dispute resolution prior to requesting independent  
175.2 informal dispute resolution.

175.3 ~~(b) Upon~~ (d) Within five calendar days of receipt of a written request for an ~~arbitration~~  
175.4 ~~proceeding independent informal dispute resolution~~, the commissioner shall file with the  
175.5 Office of Administrative Hearings a request for the appointment of an ~~arbitrator~~  
175.6 administrative law judge from the Office of Administrative Hearings and simultaneously  
175.7 serve the facility with notice of the request. ~~The arbitrator for the dispute shall be an~~  
175.8 ~~administrative law judge appointed by the Office of Administrative Hearings. The disclosure~~  
175.9 ~~provisions of section 572B.12 and the notice provisions of section 572B.15, subsection (e),~~  
175.10 ~~apply. The facility and the commissioner have the right to be represented by an attorney.~~

175.11 (e) An independent informal dispute resolution proceeding shall be scheduled to occur  
175.12 within 30 calendar days of the commissioner's request to the Office of Administrative  
175.13 Hearings, unless the parties agree otherwise or the chief administrative law judge deems  
175.14 the timing to be unreasonable. The independent informal dispute resolution process must  
175.15 be completed within 60 calendar days of the facility's request.

175.16 ~~(e)~~ (f) Five working days in advance of the scheduled proceeding, the commissioner  
175.17 and the facility ~~may present~~ must submit written statements and arguments, documentary  
175.18 evidence, depositions, and ~~oral statements and arguments at the arbitration proceeding. Oral~~  
175.19 ~~statements and arguments may be made by telephone~~ any other materials supporting their  
175.20 position to the administrative law judge.

175.21 (g) The independent informal dispute resolution proceeding shall be informal and  
175.22 conducted in a manner so as to allow the parties to fully present their positions and respond  
175.23 to the opposing party's positions. This may include presentation of oral statements and  
175.24 arguments at the proceeding.

175.25 ~~(d)~~ (h) Within ten working days of the close of the ~~arbitration~~ proceeding, the  
175.26 administrative law judge shall issue findings and recommendations regarding each of the  
175.27 deficiencies in dispute. The findings shall be one or more of the following:

175.28 (1) Supported in full. The citation is supported in full, with no deletion of findings and  
175.29 no change in the scope or severity assigned to the deficiency citation.

175.30 (2) Supported in substance. The citation is supported, but one or more findings are  
175.31 deleted without any change in the scope or severity assigned to the deficiency.

175.32 (3) Deficient practice cited under wrong requirement of participation. The citation is  
175.33 amended by moving it to the correct requirement of participation.

176.1 (4) Scope not supported. The citation is amended through a change in the scope assigned  
176.2 to the citation.

176.3 (5) Severity not supported. The citation is amended through a change in the severity  
176.4 assigned to the citation.

153.7 (6) No deficient practice. The citation is deleted because the findings did not support  
153.8 the citation or the negative resident outcome was unavoidable. ~~The findings of the arbitrator~~  
153.9 ~~are not binding on the commissioner.~~

153.10 (i) The findings and recommendations of the administrative law judge are not binding  
153.11 on the commissioner.

153.12 (j) Within ten calendar days of receiving the administrative law judge's findings and  
153.13 recommendations, the commissioner shall issue a recommendation to the Center for Medicare  
153.14 and Medicaid Services.

153.15 ~~(e) (k) The commissioner shall reimburse the Office of Administrative Hearings for the~~  
153.16 ~~costs incurred by that office for the arbitration proceeding. The facility shall reimburse the~~  
153.17 ~~commissioner for the proportion of the costs that represent the sum of deficiency citations~~  
153.18 ~~supported in full under paragraph (d), clause (1), or in substance under paragraph (d), clause~~  
153.19 ~~(2), divided by the total number of deficiencies disputed. A deficiency citation for which~~  
153.20 ~~the administrative law judge's sole finding is that the deficient practice was cited under the~~  
153.21 ~~wrong requirements of participation shall not be counted in the numerator or denominator~~  
153.22 ~~in the calculation of the proportion of costs.~~

153.23 EFFECTIVE DATE. This section is effective October 1, 2024, or upon federal approval,  
153.24 whichever is later, and applies to appeals of deficiencies which are issued after October 1,  
153.25 2024, or on or after the date upon which federal approval is obtained, whichever is later.  
153.26 The commissioner of health shall notify the revisor of statutes when federal approval is  
153.27 obtained.

153.28 Sec. 33. Minnesota Statutes 2022, section 144A.471, is amended by adding a subdivision  
153.29 to read:

153.30 Subd. 1a. **Licensure under other law.** A home care licensee must not provide sleeping  
153.31 accommodations as a provision of home care services. For purposes of this subdivision, the  
153.32 provision of sleeping accommodations and assisted living services under section 144G.08,  
153.33 subdivision 9, requires assisted living licensure under chapter 144G. This subdivision does  
154.1 not apply to settings exempt from assisted living licensure under section 144G.08, subdivision  
154.2 7.

154.3 Sec. 34. Minnesota Statutes 2022, section 144A.474, subdivision 13, is amended to read:

154.4 Subd. 13. **Home care surveyor training.** (a) Before conducting a home care survey,  
154.5 each home care surveyor must receive training on the following topics:

- 154.6 (1) Minnesota home care licensure requirements;
- 154.7 (2) Minnesota home care bill of rights;
- 154.8 (3) Minnesota Vulnerable Adults Act and reporting of maltreatment of minors;
- 154.9 (4) principles of documentation;

176.5 (6) No deficient practice. The citation is deleted because the findings did not support  
176.6 the citation or the negative resident outcome was unavoidable. ~~The findings of the arbitrator~~  
176.7 ~~are not binding on the commissioner.~~

176.8 (i) The findings and recommendations of the administrative law judge are not binding  
176.9 on the commissioner.

176.10 (j) Within ten calendar days of receiving the administrative law judge's findings and  
176.11 recommendations, the commissioner shall issue a recommendation to the Center for Medicare  
176.12 and Medicaid Services.

176.13 ~~(e) (k) The commissioner shall reimburse the Office of Administrative Hearings for the~~  
176.14 ~~costs incurred by that office for the arbitration proceeding. The facility shall reimburse the~~  
176.15 ~~commissioner for the proportion of the costs that represent the sum of deficiency citations~~  
176.16 ~~supported in full under paragraph (d), clause (1), or in substance under paragraph (d), clause~~  
176.17 ~~(2), divided by the total number of deficiencies disputed. A deficiency citation for which~~  
176.18 ~~the administrative law judge's sole finding is that the deficient practice was cited under the~~  
176.19 ~~wrong requirements of participation shall not be counted in the numerator or denominator~~  
176.20 ~~in the calculation of the proportion of costs.~~

176.21 EFFECTIVE DATE. This section is effective October 1, 2024, or upon federal approval,  
176.22 whichever is later, and applies to appeals of deficiencies which are issued after October 1,  
176.23 2024, or on or after the date upon which federal approval is obtained, whichever is later.  
176.24 The commissioner of health shall notify the revisor of statutes when federal approval is  
176.25 obtained.

176.26 Sec. 33. Minnesota Statutes 2022, section 144A.471, is amended by adding a subdivision  
176.27 to read:

176.28 Subd. 1a. **Licensure under other law.** A home care licensee must not provide sleeping  
176.29 accommodations as a provision of home care services. For purposes of this subdivision, the  
176.30 provision of sleeping accommodations and assisted living services under section 144G.08,  
176.31 subdivision 9, requires assisted living facility licensure under chapter 144G. This subdivision  
176.32 does not apply to those settings exempt from assisted living facility licensure under section  
176.33 144G.08, subdivision 7.

177.1 Sec. 34. Minnesota Statutes 2022, section 144A.474, subdivision 13, is amended to read:

177.2 Subd. 13. **Home care surveyor training.** (a) Before conducting a home care survey,  
177.3 each home care surveyor must receive training on the following topics:

- 177.4 (1) Minnesota home care licensure requirements;
- 177.5 (2) Minnesota home care bill of rights;
- 177.6 (3) Minnesota Vulnerable Adults Act and reporting of maltreatment of minors;
- 177.7 (4) principles of documentation;

154.10 (5) survey protocol and processes;  
154.11 (6) Offices of the Ombudsman roles;  
154.12 (7) Office of Health Facility Complaints;  
154.13 (8) Minnesota landlord-tenant ~~and housing with services~~ laws;  
154.14 (9) types of payors for home care services; and  
154.15 (10) Minnesota Nurse Practice Act for nurse surveyors.  
154.16 (b) Materials used for the training in paragraph (a) shall be posted on the department  
154.17 website. Requisite understanding of these topics will be reviewed as part of the quality  
154.18 improvement plan in section 144A.483.  
154.19 Sec. 35. Minnesota Statutes 2023 Supplement, section 144A.4791, subdivision 10, is  
154.20 amended to read:  
154.21 Subd. 10. **Termination of service plan.** (a) If a home care provider terminates a service  
154.22 plan with a client, and the client continues to need home care services, the home care provider  
154.23 shall provide the client and the client's representative, if any, with a written notice of  
154.24 termination which includes the following information:  
154.25 (1) the effective date of termination;  
154.26 (2) the reason for termination;  
154.27 (3) for clients age 18 or older, a statement that the client may contact the Office of  
154.28 Ombudsman for Long-Term Care to request an advocate to assist regarding the termination  
154.29 and contact information for the office, including the office's central telephone number;  
155.1 (4) a list of known licensed home care providers in the client's immediate geographic  
155.2 area;  
155.3 (5) a statement that the home care provider will participate in a coordinated transfer of  
155.4 care of the client to another home care provider, health care provider, or caregiver, as  
155.5 required by the home care bill of rights, section 144A.44, subdivision 1, clause (17); and  
155.6 (6) the name and contact information of a person employed by the home care provider  
155.7 with whom the client may discuss the notice of termination; ~~and~~.  
155.8 ~~(7) if applicable, a statement that the notice of termination of home care services does~~  
155.9 ~~not constitute notice of termination of any housing contract.~~  
155.10 (b) When the home care provider voluntarily discontinues services to all clients, the  
155.11 home care provider must notify the commissioner, lead agencies, and ombudsman for  
155.12 long-term care about its clients and comply with the requirements in this subdivision.

177.8 (5) survey protocol and processes;  
177.9 (6) Offices of the Ombudsman roles;  
177.10 (7) Office of Health Facility Complaints;  
177.11 (8) Minnesota landlord-tenant ~~and housing with services~~ laws;  
177.12 (9) types of payors for home care services; and  
177.13 (10) Minnesota Nurse Practice Act for nurse surveyors.  
177.14 (b) Materials used for the training in paragraph (a) shall be posted on the department  
177.15 website. Requisite understanding of these topics will be reviewed as part of the quality  
177.16 improvement plan in section 144A.483.  
177.17 Sec. 35. Minnesota Statutes 2023 Supplement, section 144A.4791, subdivision 10, is  
177.18 amended to read:  
177.19 Subd. 10. **Termination of service plan.** (a) If a home care provider terminates a service  
177.20 plan with a client, and the client continues to need home care services, the home care provider  
177.21 shall provide the client and the client's representative, if any, with a written notice of  
177.22 termination which includes the following information:  
177.23 (1) the effective date of termination;  
177.24 (2) the reason for termination;  
177.25 (3) for clients age 18 or older, a statement that the client may contact the Office of  
177.26 Ombudsman for Long-Term Care to request an advocate to assist regarding the termination  
177.27 and contact information for the office, including the office's central telephone number;  
177.28 (4) a list of known licensed home care providers in the client's immediate geographic  
177.29 area;  
178.1 (5) a statement that the home care provider will participate in a coordinated transfer of  
178.2 care of the client to another home care provider, health care provider, or caregiver, as  
178.3 required by the home care bill of rights, section 144A.44, subdivision 1, clause (17); and  
178.4 (6) the name and contact information of a person employed by the home care provider  
178.5 with whom the client may discuss the notice of termination; ~~and~~.  
178.6 ~~(7) if applicable, a statement that the notice of termination of home care services does~~  
178.7 ~~not constitute notice of termination of any housing contract.~~  
178.8 (b) When the home care provider voluntarily discontinues services to all clients, the  
178.9 home care provider must notify the commissioner, lead agencies, and ombudsman for  
178.10 long-term care about its clients and comply with the requirements in this subdivision.

155.13 Sec. 36. Minnesota Statutes 2022, section 144E.16, subdivision 7, is amended to read:

155.14 Subd. 7. **Stroke transport protocols.** Regional emergency medical services programs  
155.15 and any ambulance service licensed under this chapter must develop stroke transport  
155.16 protocols. The protocols must include standards of care for triage and transport of acute  
155.17 stroke patients within a specific time frame from symptom onset until transport to the most  
155.18 appropriate designated acute stroke ready hospital, primary stroke center,  
155.19 thrombectomy-capable stroke center, or comprehensive stroke center.

155.20 Sec. 37. Minnesota Statutes 2022, section 144G.08, subdivision 29, is amended to read:

155.21 Subd. 29. **Licensed health professional.** "Licensed health professional" means a person  
155.22 ~~licensed in Minnesota to practice a profession described in section 214.01, subdivision 2,~~  
155.23 other than a registered nurse or licensed practical nurse, who provides assisted living services  
155.24 within the scope of practice of that person's health occupation license, registration, or  
155.25 certification as a regulated person who is licensed by an appropriate Minnesota state board  
155.26 or agency.

155.27 Sec. 38. Minnesota Statutes 2022, section 144G.10, is amended by adding a subdivision  
155.28 to read:

155.29 Subd. 5. **Protected title; restriction on use.** (a) Effective January 1, 2026, no person  
155.30 or entity may use the phrase "assisted living," whether alone or in combination with other  
155.31 words and whether orally or in writing, to: advertise; market; or otherwise describe, offer,  
156.1 or promote itself, or any housing, service, service package, or program that it provides  
156.2 within this state, unless the person or entity is a licensed assisted living facility that meets  
156.3 the requirements of this chapter. A person or entity entitled to use the phrase "assisted living"  
156.4 shall use the phrase only in the context of its participation that meets the requirements of  
156.5 this chapter.

156.6 (b) Effective January 1, 2026, the licensee's name for a new assisted living facility may  
156.7 not include the terms "home care" or "nursing home."

156.8 Sec. 39. Minnesota Statutes 2022, section 144G.16, subdivision 6, is amended to read:

156.9 Subd. 6. **Requirements for notice and transfer.** A provisional licensee whose license  
156.10 is denied must comply with the requirements for notification and the coordinated move of  
156.11 residents in sections 144G.52 and 144G.55. If the license denial is upheld by the  
156.12 reconsideration process, the licensee must submit a draft closure plan as required by section  
156.13 144G.57 within ten calendar days of receipt of the reconsideration decision and submit a  
156.14 final plan within 30 days.

156.15 Sec. 40. Minnesota Statutes 2023 Supplement, section 145.561, subdivision 4, is amended  
156.16 to read:

156.17 Subd. 4. **988 telecommunications fee.** (a) In compliance with the National Suicide  
156.18 Hotline Designation Act of 2020, ~~the commissioner shall impose a monthly statewide fee~~  
156.19 ~~on each subscriber of a wireline, wireless, or IP-enabled voice service at a rate that provides~~

178.11 Sec. 36. Minnesota Statutes 2022, section 144E.16, subdivision 7, is amended to read:

178.12 Subd. 7. **Stroke transport protocols.** Regional emergency medical services programs  
178.13 and any ambulance service licensed under this chapter must develop stroke transport  
178.14 protocols. The protocols must include standards of care for triage and transport of acute  
178.15 stroke patients within a specific time frame from symptom onset until transport to the most  
178.16 appropriate designated acute stroke ready hospital, primary stroke center,  
178.17 thrombectomy-capable stroke center, or comprehensive stroke center.

178.18 Sec. 37. Minnesota Statutes 2022, section 144G.08, subdivision 29, is amended to read:

178.19 Subd. 29. **Licensed health professional.** "Licensed health professional" means a person  
178.20 ~~licensed in Minnesota to practice a profession described in section 214.01, subdivision 2,~~  
178.21 other than a registered nurse or licensed practical nurse, who provides assisted living services  
178.22 within the scope of practice of that person's health occupation license, registration, or  
178.23 certification as a regulated person who is licensed by an appropriate Minnesota state board  
178.24 or agency.

178.25 Sec. 38. Minnesota Statutes 2022, section 144G.10, is amended by adding a subdivision  
178.26 to read:

178.27 Subd. 5. **Protected title; restriction on use.** (a) Effective January 1, 2026, no person  
178.28 or entity may use the phrase "assisted living," whether alone or in combination with other  
178.29 words and whether orally or in writing, to: advertise; market; or otherwise describe, offer,  
178.30 or promote itself, or any housing, service, service package, or program that it provides  
178.31 within this state, unless the person or entity is a licensed assisted living facility that meets  
178.32 the requirements of this chapter. A person or entity entitled to use the phrase "assisted living"  
179.1 shall use the phrase only in the context of its participation that meets the requirements of  
179.2 this chapter.

179.3 (b) Effective January 1, 2026, the licensee's name for a new assisted living facility may  
179.4 not include the terms "home care" or "nursing home."

179.5 Sec. 39. Minnesota Statutes 2022, section 144G.16, subdivision 6, is amended to read:

179.6 Subd. 6. **Requirements for notice and transfer.** A provisional licensee whose license  
179.7 is denied must comply with the requirements for notification and the coordinated move of  
179.8 residents in sections 144G.52 and 144G.55. If the license denial is upheld by the  
179.9 reconsideration process, the licensee must submit a closure plan as required by section  
179.10 144G.57 within ten calendar days of receipt of the reconsideration decision.

119.17 Sec. 23. Minnesota Statutes 2023 Supplement, section 145.561, subdivision 4, is amended  
119.18 to read:

119.19 Subd. 4. **988 telecommunications fee.** (a) In compliance with the National Suicide  
119.20 Hotline Designation Act of 2020, ~~the commissioner shall impose a monthly statewide fee~~  
119.21 ~~on each subscriber of a wireline, wireless, or IP-enabled voice service at a rate that provides~~



156.20 must pay a monthly fee to provide for the robust creation, operation, and maintenance of a  
156.21 statewide 988 suicide prevention and crisis system.

156.22 ~~(b) The commissioner shall annually recommend to the Public Utilities Commission an~~  
156.23 ~~adequate and appropriate fee to implement this section. The amount of the fee must comply~~  
156.24 ~~with the limits in paragraph (c). The commissioner shall provide telecommunication service~~  
156.25 ~~providers and carriers a minimum of 45 days' notice of each fee change.~~

156.26 ~~(e)~~ (b) The amount of the 988 telecommunications fee ~~must not be more than 25~~ is 12  
156.27 cents per month ~~on or after January 1, 2024~~, for each consumer access line, including trunk  
156.28 equivalents as designated by the ~~commission~~ Public Utilities Commission pursuant to section  
156.29 403.11, subdivision 1. The 988 telecommunications fee must be the same for all subscribers.

156.30 ~~(d)~~ (c) Each wireline, wireless, and IP-enabled voice telecommunication service provider  
156.31 shall collect the 988 telecommunications fee and transfer the amounts collected to the  
157.1 commissioner of public safety in the same manner as provided in section 403.11, subdivision  
157.2 1, paragraph (d).

157.3 ~~(e)~~ (d) The commissioner of public safety shall deposit the money collected from the  
157.4 988 telecommunications fee to the 988 special revenue account established in subdivision  
157.5 3.

157.6 ~~(f)~~ (e) All 988 telecommunications fee revenue must be used to supplement, and not  
157.7 supplant, federal, state, and local funding for suicide prevention.

157.8 ~~(g)~~ (f) The 988 telecommunications fee amount shall be adjusted as needed to provide  
157.9 for continuous operation of the lifeline centers and 988 hotline, volume increases, and  
157.10 maintenance.

157.11 ~~(h)~~ (g) The commissioner shall annually report to the Federal Communications  
157.12 Commission on revenue generated by the 988 telecommunications fee.

157.13 **EFFECTIVE DATE.** This section is effective September 1, 2024.

157.14 Sec. 41. Minnesota Statutes 2022, section 146B.03, subdivision 7a, is amended to read:

157.15 Subd. 7a. **Supervisors.** (a) A technician must have been licensed in Minnesota or in a  
157.16 jurisdiction with which Minnesota has reciprocity for at least:

157.17 (1) two years as a tattoo technician licensed under section 146B.03, subdivision 4, 6, or  
157.18 8, in order to supervise a temporary tattoo technician; or

157.19 (2) one year as a body piercing technician licensed under section 146B.03, subdivision  
157.20 4, 6, or 8, or must have performed at least 500 body piercings, in order to supervise a  
157.21 temporary body piercing technician.

157.22 (b) Any technician who agrees to supervise more than two temporary tattoo technicians  
157.23 during the same time period, or more than four body piercing technicians during the same  
157.24 time period, must provide to the commissioner a supervisory plan that describes how the

119.22 must pay a monthly fee to provide for the robust creation, operation, and maintenance of a  
119.23 statewide 988 suicide prevention and crisis system.

119.24 ~~(b) The commissioner shall annually recommend to the Public Utilities Commission an~~  
119.25 ~~adequate and appropriate fee to implement this section. The amount of the fee must comply~~  
119.26 ~~with the limits in paragraph (c). The commissioner shall provide telecommunication service~~  
119.27 ~~providers and carriers a minimum of 45 days' notice of each fee change.~~

119.28 ~~(e)~~ (b) The amount of the 988 telecommunications fee ~~must not be more than 25~~ is 12  
119.29 cents per month ~~on or after January 1, 2024~~, for each consumer access line, including trunk  
119.30 equivalents as designated by the ~~commission~~ Public Utilities Commission pursuant to section  
119.31 403.11, subdivision 1. The 988 telecommunications fee must be the same for all subscribers.

120.1 ~~(d)~~ (c) Each wireline, wireless, and IP-enabled voice telecommunication service provider  
120.2 shall collect the 988 telecommunications fee and transfer the amounts collected to the  
120.3 commissioner of public safety in the same manner as provided in section 403.11, subdivision  
120.4 1, paragraph (d).

120.5 ~~(e)~~ (d) The commissioner of public safety shall deposit the money collected from the  
120.6 988 telecommunications fee to the 988 special revenue account established in subdivision  
120.7 3.

120.8 ~~(f)~~ (e) All 988 telecommunications fee revenue must be used to supplement, and not  
120.9 supplant, federal, state, and local funding for suicide prevention.

120.10 ~~(g)~~ (f) The 988 telecommunications fee amount shall be adjusted as needed to provide  
120.11 for continuous operation of the lifeline centers and 988 hotline, volume increases, and  
120.12 maintenance.

120.13 ~~(h)~~ (g) The commissioner shall annually report to the Federal Communications  
120.14 Commission on revenue generated by the 988 telecommunications fee.

120.15 **EFFECTIVE DATE.** This section is effective September 1, 2024.

179.11 Sec. 40. Minnesota Statutes 2022, section 146B.03, subdivision 7a, is amended to read:

179.12 Subd. 7a. **Supervisors.** (a) A technician must have been licensed in Minnesota or in a  
179.13 jurisdiction with which Minnesota has reciprocity for at least:

179.14 (1) two years as a tattoo technician licensed under section 146B.03, subdivision 4, 6, or  
179.15 8, in order to supervise a temporary tattoo technician; or

179.16 (2) one year as a body piercing technician licensed under section 146B.03, subdivision  
179.17 4, 6, or 8, or must have performed at least 500 body piercings, in order to supervise a  
179.18 temporary body piercing technician.

179.19 (b) Any technician who agrees to supervise more than two temporary tattoo technicians  
179.20 during the same time period, or more than four body piercing technicians during the same  
179.21 time period, must provide to the commissioner a supervisory plan that describes how the

157.25 technician will provide supervision to each temporary technician in accordance with section  
157.26 146B.01, subdivision 28.

157.27 (c) The supervisory plan must include, at a minimum:

157.28 (1) the areas of practice under supervision;

157.29 (2) the anticipated supervision hours per week;

157.30 (3) the anticipated duration of the training period; and

158.1 (4) the method of providing supervision if there are multiple technicians being supervised  
158.2 during the same time period.

158.3 (d) If the supervisory plan is terminated before completion of the technician's supervised  
158.4 practice, the supervisor must notify the commissioner in writing within 14 days of the change  
158.5 in supervision and include an explanation of why the plan was not completed.

158.6 (e) The commissioner may refuse to approve as a supervisor a technician who has been  
158.7 disciplined in Minnesota or in another jurisdiction after considering the criteria in section  
158.8 146B.02, subdivision 10, paragraph (b).

158.9 Sec. 42. Minnesota Statutes 2022, section 146B.10, subdivision 1, is amended to read:

158.10 Subdivision 1. **Licensing fees.** (a) The fee for the initial technician licensure application  
158.11 and biennial licensure renewal application is \$420.

158.12 (b) The fee for temporary technician licensure application is \$240.

158.13 (c) The fee for the temporary guest artist license application is \$140.

158.14 (d) The fee for a dual body art technician license application is \$420.

158.15 (e) The fee for a provisional establishment license application required in section 146B.02,  
158.16 subdivision 5, paragraph (c), is \$1,500.

158.17 (f) The fee for an initial establishment license application and the two-year license  
158.18 renewal period application required in section 146B.02, subdivision 2, paragraph (b), is  
158.19 \$1,500.

158.20 (g) The fee for a temporary body art establishment event permit application is \$200.

158.21 (h) The commissioner shall prorate the initial two-year technician license fee based on  
158.22 the number of months in the initial licensure period. The commissioner shall prorate the  
158.23 first renewal fee for the establishment license based on the number of months from issuance  
158.24 of the provisional license to the first renewal.

158.25 (i) The fee for verification of licensure to other states is \$25.

179.22 technician will provide supervision to each temporary technician in accordance with section  
179.23 146B.01, subdivision 28.

179.24 (c) The supervisory plan must include, at a minimum:

179.25 (1) the areas of practice under supervision;

179.26 (2) the anticipated supervision hours per week;

179.27 (3) the anticipated duration of the training period; and

179.28 (4) the method of providing supervision if there are multiple technicians being supervised  
179.29 during the same time period.

180.1 (d) If the supervisory plan is terminated before completion of the technician's supervised  
180.2 practice, the supervisor must notify the commissioner in writing within 14 days of the change  
180.3 in supervision and include an explanation of why the plan was not completed.

180.4 (e) The commissioner may refuse to approve as a supervisor a technician who has been  
180.5 disciplined in Minnesota or in another jurisdiction after considering the criteria in section  
180.6 146B.02, subdivision 10, paragraph (b).

180.7 Sec. 41. Minnesota Statutes 2022, section 146B.10, subdivision 1, is amended to read:

180.8 Subdivision 1. **Licensing fees.** (a) The fee for the initial technician licensure application  
180.9 and biennial licensure renewal application is \$420.

180.10 (b) The fee for temporary technician licensure application is \$240.

180.11 (c) The fee for the temporary guest artist license application is \$140.

180.12 (d) The fee for a dual body art technician license application is \$420.

180.13 (e) The fee for a provisional establishment license application required in section 146B.02,  
180.14 subdivision 5, paragraph (c), is \$1,500.

180.15 (f) The fee for an initial establishment license application and the two-year license  
180.16 renewal period application required in section 146B.02, subdivision 2, paragraph (b), is  
180.17 \$1,500.

180.18 (g) The fee for a temporary body art establishment event permit application is \$200.

180.19 (h) The commissioner shall prorate the initial two-year technician license fee based on  
180.20 the number of months in the initial licensure period. The commissioner shall prorate the  
180.21 first renewal fee for the establishment license based on the number of months from issuance  
180.22 of the provisional license to the first renewal.

180.23 (i) The fee for verification of licensure to other states is \$25.

158.26 ~~(j) The fee to reissue a provisional establishment license that relocates prior to inspection~~  
158.27 ~~and removal of provisional status is \$350. The expiration date of the provisional license~~  
158.28 ~~does not change.~~

158.29 ~~(k) (i)~~ (i) The fee to change an establishment name or establishment type, such as tattoo,  
158.30 piercing, or dual, is \$50.

159.1 Sec. 43. Minnesota Statutes 2022, section 146B.10, subdivision 3, is amended to read:

159.2 Subd. 3. **Deposit.** Fees collected by the commissioner under this section must be deposited  
159.3 in the state government special revenue fund. All fees are nonrefundable.

159.4 Sec. 44. Minnesota Statutes 2022, section 149A.02, subdivision 3b, is amended to read:

159.5 Subd. 3b. **Burial site services.** "Burial site services" means any services sold or offered  
159.6 for sale directly to the public for use in connection with the final disposition of a dead human  
159.7 body but does not include services provided under a transportation protection agreement.

159.8 Sec. 45. Minnesota Statutes 2022, section 149A.02, subdivision 23, is amended to read:

159.9 Subd. 23. **Funeral services.** (a) "Funeral services" means any services which may be  
159.10 used to: (1) care for and prepare dead human bodies for burial, alkaline hydrolysis, cremation,  
159.11 or other final disposition; and (2) arrange, supervise, or conduct the funeral ceremony or  
159.12 the final disposition of dead human bodies.

159.13 (b) Funeral service does not include a transportation protection agreement.

159.14 Sec. 46. Minnesota Statutes 2022, section 149A.02, is amended by adding a subdivision  
159.15 to read:

159.16 Subd. 38a. **Transportation protection agreement.** "Transportation protection agreement"  
159.17 means an agreement that is primarily for the purpose of transportation and subsequent  
159.18 transportation of the remains of a dead human body.

159.19 Sec. 47. Minnesota Statutes 2022, section 149A.65, is amended to read:

159.20 **149A.65 FEES.**

159.21 Subdivision 1. **Generally.** This section establishes the application fees for registrations,  
159.22 examinations, initial and renewal licenses, and late fees authorized under the provisions of  
159.23 this chapter.

159.24 Subd. 2. **Mortuary science fees.** Fees for mortuary science are:

159.25 (1) \$75 for the initial and renewal registration of a mortuary science intern;

159.26 (2) \$125 for the mortuary science examination;

159.27 (3) \$200 for ~~issuance of~~ initial and renewal mortuary science ~~licenses~~ license applications;

159.28 (4) \$100 late fee charge for a license renewal application; and

180.24 ~~(j) The fee to reissue a provisional establishment license that relocates prior to inspection~~  
180.25 ~~and removal of provisional status is \$350. The expiration date of the provisional license~~  
180.26 ~~does not change.~~

180.27 ~~(k) (i)~~ (i) The fee to change an establishment name or establishment type, such as tattoo,  
180.28 piercing, or dual, is \$50.

181.1 Sec. 42. Minnesota Statutes 2022, section 146B.10, subdivision 3, is amended to read:

181.2 Subd. 3. **Deposit.** Fees collected by the commissioner under this section must be deposited  
181.3 in the state government special revenue fund. All fees are nonrefundable.

181.4 Sec. 43. Minnesota Statutes 2022, section 149A.65, is amended to read:

181.5 **149A.65 FEES.**

181.6 Subdivision 1. **Generally.** This section establishes the application fees for registrations,  
181.7 examinations, initial and renewal licenses, and late fees authorized under the provisions of  
181.8 this chapter.

181.9 Subd. 2. **Mortuary science fees.** Fees for mortuary science are:

181.10 (1) \$75 for the initial and renewal registration of a mortuary science intern;

181.11 (2) \$125 for the mortuary science examination;

181.12 (3) \$200 for ~~issuance of~~ initial and renewal mortuary science ~~licenses~~ license applications;

181.13 (4) \$100 late fee charge for a license renewal application; and

160.1 (5) \$250 for ~~issuing a~~ an application for mortuary science license by endorsement.

160.2 Subd. 3. **Funeral directors.** The license renewal application fee for funeral directors is

160.3 \$200. The late fee charge for a license renewal is \$100.

160.4 Subd. 4. **Funeral establishments.** The initial and renewal application fee for funeral

160.5 establishments is \$425. The late fee charge for a license renewal is \$100.

160.6 Subd. 5. **Crematories.** The initial and renewal application fee for a crematory is \$425.

160.7 The late fee charge for a license renewal is \$100.

160.8 Subd. 6. **Alkaline hydrolysis facilities.** The initial and renewal application fee for an

160.9 alkaline hydrolysis facility is \$425. The late fee charge for a license renewal is \$100.

160.10 Subd. 7. **State government special revenue fund.** Fees collected by the commissioner

160.11 under this section must be deposited in the state treasury and credited to the state government

160.12 special revenue fund. All fees are nonrefundable.

160.13 Sec. 48. Minnesota Statutes 2022, section 149A.97, subdivision 2, is amended to read:

160.14 Subd. 2. **Scope and requirements.** This section shall not apply to a transportation

160.15 protection agreement or to any funeral goods or burial site goods purchased and delivered,

160.16 either at purchase or within a commercially reasonable amount of time thereafter. When

160.17 prior to the death of any person, that person or another, on behalf of that person, enters into

160.18 any transaction, makes a contract, or any series or combination of transactions or contracts

160.19 with a funeral provider lawfully doing business in Minnesota, other than an insurance

160.20 company licensed to do business in Minnesota selling approved insurance or annuity

160.21 products, by the terms of which, goods or services related to the final disposition of that

160.22 person will be furnished at-need, then the total of all money paid by the terms of the

160.23 transaction, contract, or series or combination of transactions or contracts shall be held in

160.24 trust for the purpose for which it has been paid. The person for whose benefit the money

160.25 was paid shall be known as the beneficiary, the person or persons who paid the money shall

160.26 be known as the purchaser, and the funeral provider shall be known as the depositor.

160.27 Sec. 49. Minnesota Statutes 2022, section 152.22, is amended by adding a subdivision to

160.28 read:

160.29 Subd. 19. **Veteran.** "Veteran" means an individual who satisfies the requirements in

160.30 section 197.447 and is receiving care from the United States Department of Veterans Affairs.

161.1 Sec. 50. Minnesota Statutes 2022, section 152.25, subdivision 2, is amended to read:

161.2 Subd. 2. **Range of compounds and dosages; report.** The commissioner shall review

161.3 and publicly report the existing medical and scientific literature regarding the range of

161.4 recommended dosages for each qualifying condition and the range of chemical compositions

161.5 of any plant of the genus cannabis that will likely be medically beneficial for each of the

161.6 qualifying medical conditions. The commissioner shall make this information available to

161.7 patients with qualifying medical conditions beginning December 1, 2014, and update the

181.14 (5) \$250 for ~~issuing a~~ an application for mortuary science license by endorsement.

181.15 Subd. 3. **Funeral directors.** The license renewal application fee for funeral directors is

181.16 \$200. The late fee charge for a license renewal is \$100.

181.17 Subd. 4. **Funeral establishments.** The initial and renewal application fee for funeral

181.18 establishments is \$425. The late fee charge for a license renewal is \$100.

181.19 Subd. 5. **Crematories.** The initial and renewal application fee for a crematory is \$425.

181.20 The late fee charge for a license renewal is \$100.

181.21 Subd. 6. **Alkaline hydrolysis facilities.** The initial and renewal application fee for an

181.22 alkaline hydrolysis facility is \$425. The late fee charge for a license renewal is \$100.

181.23 Subd. 7. **State government special revenue fund.** Fees collected by the commissioner

181.24 under this section must be deposited in the state treasury and credited to the state government

181.25 special revenue fund. All fees are nonrefundable.

161.8 information ~~annually~~ every three years. The commissioner may consult with the independent  
161.9 laboratory under contract with the manufacturer or other experts in reporting the range of  
161.10 recommended dosages for each qualifying medical condition, the range of chemical  
161.11 compositions that will likely be medically beneficial, and any risks of noncannabis drug  
161.12 interactions. The commissioner shall consult with each manufacturer on an annual basis on  
161.13 medical cannabis offered by the manufacturer. The list of medical cannabis offered by a  
161.14 manufacturer shall be published on the Department of Health website.

161.15 Sec. 51. Minnesota Statutes 2023 Supplement, section 152.28, subdivision 1, is amended  
161.16 to read:

161.17 Subdivision 1. **Health care practitioner duties.** (a) Prior to a patient's enrollment in  
161.18 the registry program, a health care practitioner shall:

161.19 (1) determine, in the health care practitioner's medical judgment, whether a patient suffers  
161.20 from a qualifying medical condition, and, if so determined, provide the patient with a  
161.21 certification of that diagnosis;

161.22 (2) advise patients, registered designated caregivers, and parents, legal guardians, or  
161.23 spouses who are acting as caregivers of the existence of any nonprofit patient support groups  
161.24 or organizations;

161.25 (3) provide explanatory information from the commissioner to patients with qualifying  
161.26 medical conditions, including disclosure to all patients about the experimental nature of  
161.27 therapeutic use of medical cannabis; the possible risks, benefits, and side effects of the  
161.28 proposed treatment; the application and other materials from the commissioner; and provide  
161.29 patients with the Tennessen warning as required by section 13.04, subdivision 2; and

161.30 (4) agree to continue treatment of the patient's qualifying medical condition and report  
161.31 medical findings to the commissioner.

161.32 (b) Upon notification from the commissioner of the patient's enrollment in the registry  
161.33 program, the health care practitioner shall:

162.1 (1) participate in the patient registry reporting system under the guidance and supervision  
162.2 of the commissioner;

162.3 (2) report health records of the patient throughout the ongoing treatment of the patient  
162.4 to the commissioner in a manner determined by the commissioner and in accordance with  
162.5 subdivision 2;

162.6 (3) determine, ~~on a yearly basis~~ every three years, if the patient continues to suffer from  
162.7 a qualifying medical condition and, if so, issue the patient a new certification of that  
162.8 diagnosis; and

162.9 (4) otherwise comply with all requirements developed by the commissioner.

162.10 (c) A health care practitioner may utilize telehealth, as defined in section 62A.673,  
162.11 subdivision 2, for certifications and recertifications.

162.12 (d) Nothing in this section requires a health care practitioner to participate in the registry  
162.13 program.

162.14 Sec. 52. Minnesota Statutes 2022, section 256R.02, subdivision 20, is amended to read:

162.15 Subd. 20. **Facility average case mix index.** "Facility average case mix index" or "CMI"  
162.16 means a numerical score that describes the relative resource use for all residents within the  
162.17 case mix ~~classifications under the resource utilization group (RUG)~~ classification system  
162.18 prescribed by the commissioner based on an assessment of each resident. The facility average  
162.19 CMI shall be computed as the standardized days divided by the sum of the facility's resident  
162.20 days. The case mix indices used shall be based on the system prescribed in section 256R.17.

162.21 Sec. 53. Minnesota Statutes 2022, section 259.52, subdivision 2, is amended to read:

162.22 Subd. 2. **Requirement to search registry before adoption petition can be granted;**  
162.23 **proof of search.** No petition for adoption may be granted unless the agency supervising  
162.24 the adoptive placement, the birth mother of the child, the putative father who registered or  
162.25 the legal father, or, in the case of a stepparent or relative adoption, the county agency  
162.26 responsible for the report required under section 259.53, subdivision 1, requests that the  
162.27 commissioner of health search the registry to determine whether a putative father is registered  
162.28 in relation to a child who is or may be the subject of an adoption petition. The search required  
162.29 by this subdivision must be conducted no sooner than 31 days following the birth of the  
162.30 child. A search of the registry may be proven by the production of a certified copy of the  
162.31 registration form or by a certified statement of the commissioner of health that after a search  
162.32 no registration of a putative father in relation to a child who is or may be the subject of an  
163.1 adoption petition could be located. The filing of a certified copy of an order from a juvenile  
163.2 protection matter under chapter 260C containing a finding that certification of the requisite  
163.3 search of the Minnesota Fathers' Adoption Registry was filed with the court in that matter  
163.4 shall also constitute proof of search. Certification that the Minnesota Fathers' Adoption  
163.5 Registry has been searched must be filed with the court prior to entry of any final order of  
163.6 adoption. In addition to the search required by this subdivision, the agency supervising the  
163.7 adoptive placement, the birth mother of the child, or, in the case of a stepparent or relative  
163.8 adoption, the social services agency responsible for the report under section 259.53,  
163.9 subdivision 1, or the responsible social services agency that is a petitioner in a juvenile  
163.10 protection matter under chapter 260C may request that the commissioner of health search  
163.11 the registry at any time. Search requirements of this section do not apply when the responsible  
163.12 social services agency is proceeding under Safe Place for Newborns, section 260C.139.

163.13 Sec. 54. Minnesota Statutes 2022, section 259.52, subdivision 4, is amended to read:

163.14 Subd. 4. **Classification of registry data.** (a) Data in the fathers' adoption registry,  
163.15 including all data provided in requesting the search of the registry, are private data on  
163.16 individuals, as defined in section 13.02, subdivision 2, and are nonpublic data with respect

181.26 Sec. 44. Minnesota Statutes 2022, section 256R.02, subdivision 20, is amended to read:

181.27 Subd. 20. **Facility average case mix index.** "Facility average case mix index" or "CMI"  
181.28 means a numerical score that describes the relative resource use for all residents within the  
181.29 case mix ~~classifications under the resource utilization group (RUG)~~ classification system  
182.1 prescribed by the commissioner based on an assessment of each resident. The facility average  
182.2 CMI shall be computed as the standardized days divided by the sum of the facility's resident  
182.3 days. The case mix indices used shall be based on the system prescribed in section 256R.17.

163.17 to data not on individuals, as defined in section 13.02, subdivision 9. Data in the registry  
163.18 may be released to:

163.19 (1) a person who is required to search the registry under subdivision 2, if the data relate  
163.20 to the child who is or may be the subject of the adoption petition;

163.21 (2) the mother of the child listed on the putative father's registration form who the  
163.22 commissioner of health is required to notify under subdivision 1, paragraph (c);

163.23 (3) the putative father who registered himself or the legal father;

163.24 (4) a public authority as provided in subdivision 3; or

163.25 ~~(4)~~ (5) an attorney who has signed an affidavit from the commissioner of health attesting  
163.26 that the attorney represents the birth mother, the putative or legal father, or the prospective  
163.27 adoptive parents.

163.28 (b) A person who receives data under this subdivision may use the data only for purposes  
163.29 authorized under this section or other law.

164.1 Sec. 55. Minnesota Statutes 2023 Supplement, section 342.54, subdivision 2, is amended  
164.2 to read:

164.3 Subd. 2. **Duties related to the registry program.** The Division of Medical Cannabis  
164.4 must:

164.5 (1) administer the registry program according to section 342.52;

164.6 (2) provide information to patients enrolled in the registry program on the existence of  
164.7 federally approved clinical trials for the treatment of the patient's qualifying medical condition  
164.8 with medical cannabis flower or medical cannabinoid products as an alternative to enrollment  
164.9 in the registry program;

164.10 (3) maintain safety criteria with which patients must comply as a condition of participation  
164.11 in the registry program to prevent patients from undertaking any task under the influence  
164.12 of medical cannabis flower or medical cannabinoid products that would constitute negligence  
164.13 or professional malpractice;

164.14 (4) review and publicly report on existing medical and scientific literature regarding the  
164.15 range of recommended dosages for each qualifying medical condition, the range of chemical  
164.16 compositions of medical cannabis flower and medical cannabinoid products that will likely  
164.17 be medically beneficial for each qualifying medical condition, and any risks of noncannabis  
164.18 drug interactions. This information must be updated by December 1 ~~of each year~~ every three  
164.19 years. The office may consult with an independent laboratory under contract with the office  
164.20 or other experts in reporting and updating this information; and

164.21 (5) annually consult with cannabis businesses about medical cannabis that the businesses  
164.22 cultivate, manufacture, and offer for sale and post on the Division of Medical Cannabis

164.23 website a list of the medical cannabis flower and medical cannabinoid products offered for  
164.24 sale by each medical cannabis retailer.

164.25 **EFFECTIVE DATE.** This section is effective March 1, 2025.

164.26 Sec. 56. Minnesota Statutes 2023 Supplement, section 342.55, subdivision 2, is amended  
164.27 to read:

164.28 Subd. 2. **Duties upon patient's enrollment in registry program.** Upon receiving  
164.29 notification from the Division of Medical Cannabis of the patient's enrollment in the registry  
164.30 program, a health care practitioner must:

164.31 (1) participate in the patient registry reporting system under the guidance and supervision  
164.32 of the Division of Medical Cannabis;

165.1 (2) report to the Division of Medical Cannabis patient health records throughout the  
165.2 patient's ongoing treatment in a manner determined by the office and in accordance with  
165.3 subdivision 4;

165.4 (3) determine ~~on a yearly basis~~, every three years, if the patient continues to have a  
165.5 qualifying medical condition and, if so, issue the patient a new certification of that diagnosis.  
165.6 The patient assessment conducted under this clause may be conducted via telehealth, as  
165.7 defined in section 62A.673, subdivision 2; and

165.8 (4) otherwise comply with requirements established by the Office of Cannabis  
165.9 Management and the Division of Medical Cannabis.

165.10 **EFFECTIVE DATE.** This section is effective March 1, 2025.

165.11 Sec. 57. **REVISOR INSTRUCTION.**

165.12 The revisor of statutes shall substitute the term "employee" with the term "staff" in the  
165.13 following sections of Minnesota Statutes and make any grammatical changes needed without  
165.14 changing the meaning of the sentence: Minnesota Statutes, sections 144G.08, subdivisions  
165.15 18 and 36; 144G.13, subdivision 1, paragraph (c); 144G.20, subdivisions 1, 2, and 21;  
165.16 144G.30, subdivision 5; 144G.42, subdivision 8; 144G.45, subdivision 2; 144G.60,  
165.17 subdivisions 1, paragraph (c), and 3, paragraph (a); 144G.63, subdivision 2, paragraph (a),  
165.18 clause (9); 144G.64, paragraphs (a), clauses (2), (3), and (5), and (c); 144G.70, subdivision  
165.19 7; and 144G.92, subdivisions 1 and 3.

165.20 Sec. 58. **REPEALER; 340B COVERED ENTITY REPORT.**

165.21 (a) Minnesota Statutes 2022, sections 144.218, subdivision 3; 144.497; and 256R.02,  
165.22 subdivision 46, are repealed.

165.23 (b) Minnesota Statutes 2023 Supplement, sections 62J.312, subdivision 6; and 144.0528,  
165.24 subdivision 5, are repealed.

182.4 Sec. 45. **REVISOR INSTRUCTION.**

182.5 The revisor of statutes shall substitute the term "employee" with the term "staff" in the  
182.6 following sections of Minnesota Statutes and make any grammatical changes needed without  
182.7 changing the meaning of the sentence: Minnesota Statutes, sections 144G.08, subdivisions  
182.8 18 and 36; 144G.13, subdivision 1, paragraph (c); 144G.20, subdivisions 1, 2, and 21;  
182.9 144G.30, subdivision 5; 144G.42, subdivision 8; 144G.45, subdivision 2; 144G.60,  
182.10 subdivisions 1, paragraph (c), and 3, paragraph (a); 144G.63, subdivision 2, paragraph (a),  
182.11 clause (9); 144G.64, paragraphs (a), clauses (2), (3), and (5), and (c); 144G.70, subdivision  
182.12 7; and 144G.92, subdivisions 1 and 3.

182.13 Sec. 46. **REPEALER.**

182.14 (a) Minnesota Statutes 2022, sections 144.497; and 256R.02, subdivision 46, are repealed.

182.15 (b) Minnesota Statutes 2023 Supplement, section 62J.312, subdivision 6, is repealed.



- 144.12    Sec. 55. **REPEALER.**
  - 144.13    Minnesota Statutes 2023 Supplement, section 144.0528, subdivision 5, is repealed.
- SECTION 55 IS FROM ARTICLE 5 AND MATCHES WITH SENATE ARTICLE 6, SECTION 58