ARTICLE 6

DEPARTMENT OF HEALTH POLICY

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

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

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

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

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

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

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

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

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

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

ARTICLE 6

DEPARTMENT OF HEALTH POLICY

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

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

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

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

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

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

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

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

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

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

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

(1) the name of the 340B covered entity;

(2) the 340B ID of the 340B covered entity;

(3) the servicing address of the 340B covered entity; and

(4) the 340B entity type of the 340B covered entity.

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

(1) the aggregated acquisition cost for prescription drugs obtained under the 340B program;

(2) the aggregated payment amount received for drugs obtained under the 340B program and dispensed or administered to patients;

(3) the number of pricing units dispensed or administered for prescription drugs described in clause (2); and

(4) the aggregated payments made:

(i) to contract pharmacies to dispense drugs obtained under the 340B program;

(ii) to any other entity that is not the covered entity and is not a contract pharmacy for managing any aspect of the covered entity's 340B program; and

(iii) for all other expenses related to administering the 340B program.

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

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

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

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

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

(1) the name of the 340B covered entity;

(2) the 340B ID of the 340B covered entity;

(3) the servicing address of the 340B covered entity; and

(4) the 340B entity type of the 340B covered entity.

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

(1) the aggregated acquisition cost for prescription drugs obtained under the 340B program;

(2) the aggregated payment amount received for drugs obtained under the 340B program and dispensed or administered to patients;

(3) the number of pricing units dispensed or administered for prescription drugs described in clause (2); and

(4) the aggregated payments made:

(i) to contract pharmacies to dispense drugs obtained under the 340B program;

(ii) to any other entity that is not the covered entity and is not a contract pharmacy for managing any aspect of the covered entity's 340B program; and

(iii) for all other expenses related to administering the 340B program.

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

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

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

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

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

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

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

(1) the information submitted under subdivision 2; and

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

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

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

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

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

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

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

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

(1) the information submitted under subdivision 2; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

144.058 INTERPRETER SERVICES QUALITY INITIATIVE.

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

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

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

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

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

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

(iii) recommendations for appropriate fees; and

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) recommendations for appropriate fees; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) elderly waiver services under chapter 256S;

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

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

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

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

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

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

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

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

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

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

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

(2) elderly waiver services under chapter 256S;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) For reconsideration requests initiated by the facility:

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

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

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

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

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

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

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

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

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

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

(c) For reconsideration requests initiated by the facility:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(v) a criminal indictment alleging provider fraud;

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

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

(viii) nonsubmission of assessments;

(ix) late submission of assessments; or

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

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

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

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

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

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

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

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

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

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

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

(v) a criminal indictment alleging provider fraud;

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

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

(viii) nonsubmission of assessments;

(ix) late submission of assessments; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Funds may be used for:

(1) establishing or expanding rotations and clinical training;

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

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

(4) travel and lodging for students;

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

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

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

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

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

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

(c) Funds may be used for:

(1) establishing or expanding rotations and clinical training;

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

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

(4) travel and lodging for students;

(5) faculty, student, and preceptor salaries, incentives, or other financial support;

(6) development and implementation of cultural competency training;

(7) evaluations;

(8) training site improvements, fees, equipment, and supplies required to establish, maintain, or expand a training program; and

(9) supporting clinical education in which trainees are part of a primary care team model.

Sec. 20. Minnesota Statutes 2022, section 144.1911, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

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

(c) "Immigrant international medical graduate" means an international medical graduate who was born outside the United States, now resides permanently in the United States or who has entered the United States on a temporary status based on urgent humanitarian or significant public benefit reasons, and who did not enter the United States on a J1 or similar nonimmigrant visa following acceptance into a United States medical residency or fellowship program.

(d) "International medical graduate" means a physician who received a basic medical degree or qualification from a medical school located outside the United States and Canada.

(e) "Minnesota immigrant international medical graduate" means an immigrant international medical graduate who has lived in Minnesota for at least two years.

(f) "Rural community" means a statutory and home rule charter city or township that is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

(g) "Underserved community" means a Minnesota area or population included in the list of designated primary medical care health professional shortage areas, medically underserved areas, or medically underserved populations (MUPs) maintained and updated by the United States Department of Health and Human Services.

Sec. 21. Minnesota Statutes 2022, section 144.212, is amended by adding a subdivision to read:

Subd. 5a. **Replacement.** "Replacement" means a completion, addition, removal, or change made to certification items on a vital record after a vital event is registered and a record is established that has no notation of a change on a certificate and seals the prior vital record.

(5) faculty, student, and preceptor salaries, incentives, or other financial support;

(6) development and implementation of cultural competency training;

(7) evaluations;

(8) training site improvements, fees, equipment, and supplies required to establish, maintain, or expand a training program; and

(9) supporting clinical education in which trainees are part of a primary care team model.

Sec. 17. Minnesota Statutes 2022, section 144.1911, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

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

(c) "Immigrant international medical graduate" means an international medical graduate who was born outside the United States, now resides permanently in the United States or who has entered the United States on a temporary status based on urgent humanitarian or significant public benefit reasons, and who did not enter the United States on a J1 or similar nonimmigrant visa following acceptance into a United States medical residency or fellowship program.

(d) "International medical graduate" means a physician who received a basic medical degree or qualification from a medical school located outside the United States and Canada.

(e) "Minnesota immigrant international medical graduate" means an immigrant international medical graduate who has lived in Minnesota for at least two years.

(f) "Rural community" means a statutory and home rule charter city or township that is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

(g) "Underserved community" means a Minnesota area or population included in the list of designated primary medical care health professional shortage areas, medically underserved areas, or medically underserved populations (MUPs) maintained and updated by the United States Department of Health and Human Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) the establishment of a new hospital.

(b) This section does not apply to:

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

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

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

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

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

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

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

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

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

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

(2) the establishment of a new hospital.

(b) This section does not apply to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iv) the new hospital:

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

(B) will provide uncompensated care;

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

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

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

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

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

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

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

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

(21) a project approved under section 144.553;

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

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

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

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

(iv) the new hospital:

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

(B) will provide uncompensated care;

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

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

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

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

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

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

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

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

(21) a project approved under section 144.553;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) If the person believes that the information contained in the commissioner's correction order is in error, the person may ask the commissioner to reconsider the parts of the order as determined by the hospital. The implementation strategy must include how the hospital shall address the top three community health priorities identified in the community health needs assessment. Implementation strategies must be evidence-based, when available, and development and implementation of innovative programs and strategies may be supported by evaluation measures.

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

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

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

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

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

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

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

(4) publish an annual report:

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

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

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

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

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

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

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

(2) explain why they are in error; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Minnesota home care licensure requirements;

(2) Minnesota home care bill of rights;

(3) Minnesota Vulnerable Adults Act and reporting of maltreatment of minors;

(4) principles of documentation;

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

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

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

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

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

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

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

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

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

(1) Minnesota home care licensure requirements;

(2) Minnesota home care bill of rights;

(3) Minnesota Vulnerable Adults Act and reporting of maltreatment of minors;

(4) principles of documentation;

(5) survey protocol and processes;

(6) Offices of the Ombudsman roles;

(7) Office of Health Facility Complaints;

(8) Minnesota landlord-tenant ~~and housing with services~~ laws;

(9) types of payors for home care services; and

(10) Minnesota Nurse Practice Act for nurse surveyors.

(b) Materials used for the training in paragraph (a) shall be posted on the department website. Requisite understanding of these topics will be reviewed as part of the quality improvement plan in section 144A.483.

Sec. 35. Minnesota Statutes 2023 Supplement, section 144A.4791, subdivision 10, is amended to read:

Subd. 10. **Termination of service plan.** (a) If a home care provider terminates a service plan with a client, and the client continues to need home care services, the home care provider shall provide the client and the client's representative, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the reason for termination;

(3) for clients age 18 or older, a statement that the client may contact the Office of Ombudsman for Long-Term Care to request an advocate to assist regarding the termination and contact information for the office, including the office's central telephone number;

(4) a list of known licensed home care providers in the client's immediate geographic area;

(5) a statement that the home care provider will participate in a coordinated transfer of care of the client to another home care provider, health care provider, or caregiver, as required by the home care bill of rights, section 144A.44, subdivision 1, clause (17); and

(6) the name and contact information of a person employed by the home care provider with whom the client may discuss the notice of termination~~; and~~.

~~(7) if applicable, a statement that the notice of termination of home care services does not constitute notice of termination of any housing contract.~~

(b) When the home care provider voluntarily discontinues services to all clients, the home care provider must notify the commissioner, lead agencies, and ombudsman for long-term care about its clients and comply with the requirements in this subdivision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) the areas of practice under supervision;

(2) the anticipated supervision hours per week;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) the areas of practice under supervision;

(2) the anticipated supervision hours per week;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

149A.65 FEES.

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

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

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

(2) $125 for the mortuary science examination;

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

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

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

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

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

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

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

149A.65 FEES.

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

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

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

(2) $125 for the mortuary science examination;

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

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

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

Subd. 3. **Funeral directors.** The license renewal application fee for funeral directors is $200. The late fee charge for a license renewal is $100.

Subd. 4. **Funeral establishments.** The initial and renewal application fee for funeral establishments is $425. The late fee charge for a license renewal is $100.

Subd. 5. **Crematories.** The initial and renewal application fee for a crematory is $425. The late fee charge for a license renewal is $100.

Subd. 6. **Alkaline hydrolysis facilities.** The initial and renewal application fee for an alkaline hydrolysis facility is $425. The late fee charge for a license renewal is $100.

Subd. 7. **State government special revenue fund.** Fees collected by the commissioner under this section must be deposited in the state treasury and credited to the state government special revenue fund. All fees are nonrefundable.

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

Subd. 2. **Scope and requirements.** This section shall not apply to a transportation protection agreement or to any funeral goods or burial site goods purchased and delivered, either at purchase or within a commercially reasonable amount of time thereafter. When prior to the death of any person, that person or another, on behalf of that person, enters into any transaction, makes a contract, or any series or combination of transactions or contracts with a funeral provider lawfully doing business in Minnesota, other than an insurance company licensed to do business in Minnesota selling approved insurance or annuity products, by the terms of which, goods or services related to the final disposition of that person will be furnished at-need, then the total of all money paid by the terms of the transaction, contract, or series or combination of transactions or contracts shall be held in trust for the purpose for which it has been paid. The person for whose benefit the money was paid shall be known as the beneficiary, the person or persons who paid the money shall be known as the purchaser, and the funeral provider shall be known as the depositor.

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

Subd. 19. **Veteran.** "Veteran" means an individual who satisfies the requirements in section 197.447 and is receiving care from the United States Department of Veterans Affairs.

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

Subd. 2. **Range of compounds and dosages; report.** The commissioner shall review and publicly report the existing medical and scientific literature regarding the range of recommended dosages for each qualifying condition and the range of chemical compositions of any plant of the genus cannabis that will likely be medically beneficial for each of the qualifying medical conditions. The commissioner shall make this information available to patients with qualifying medical conditions beginning December 1, 2014, and update the

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

Subd. 3. **Funeral directors.** The license renewal application fee for funeral directors is $200. The late fee charge for a license renewal is $100.

Subd. 4. **Funeral establishments.** The initial and renewal application fee for funeral establishments is $425. The late fee charge for a license renewal is $100.

Subd. 5. **Crematories.** The initial and renewal application fee for a crematory is $425. The late fee charge for a license renewal is $100.

Subd. 6. **Alkaline hydrolysis facilities.** The initial and renewal application fee for an alkaline hydrolysis facility is $425. The late fee charge for a license renewal is $100.

Subd. 7. **State government special revenue fund.** Fees collected by the commissioner under this section must be deposited in the state treasury and credited to the state government special revenue fund. All fees are nonrefundable.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 57. **REVISOR INSTRUCTION.**

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

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

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

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

Sec. 45. **REVISOR INSTRUCTION.**

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

Sec. 46. **REPEALER.**

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

(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