

**SENATE  
STATE OF MINNESOTA  
NINETY-THIRD SESSION**

**S.F. No. 4573**

(SENATE AUTHORS: WIKLUND)

DATE	D-PG	OFFICIAL STATUS
03/04/2024	11913	Introduction and first reading Referred to Health and Human Services

1.1 A bill for an act

1.2 relating to health; changing provisions for public review process in rulemaking,

1.3 case mix review, and Minnesota One Health Antimicrobial Stewardship

1.4 Collaborative; modifying a definition; creating a waiver for procurement

1.5 contractors; aligning independent informal dispute resolution process; modifying

1.6 licensure requirements for assisted living and home care licensure, and body art

1.7 technicians and body art establishments; modifying medical cannabis provisions;

1.8 amending Minnesota Statutes 2022, sections 62J.61, subdivision 5; 144.058;

1.9 144.0724, subdivisions 2, 3a, 4, 6, 7, 8, 9, 11; 144.1911, subdivision 2; 144.605,

1.10 by adding a subdivision; 144A.10, subdivisions 15, 16; 144A.44, subdivision 1;

1.11 144A.471, by adding a subdivision; 144A.474, subdivision 13; 144G.08,

1.12 subdivision 29; 144G.10, by adding a subdivision; 144G.16, subdivision 6;

1.13 146B.03, subdivision 7a; 146B.10, subdivisions 1, 3; 149A.65; 152.22, by adding

1.14 a subdivision; 152.25, subdivision 2; 152.27, subdivision 6, by adding a subdivision;

1.15 Minnesota Statutes 2023 Supplement, sections 144.0526, subdivision 1; 144A.4791,

1.16 subdivision 10; 152.28, subdivision 1; 342.54, subdivision 2; 342.55, subdivision

1.17 2; repealing Minnesota Statutes 2022, section 144.497.

1.18 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

1.19 Section 1. Minnesota Statutes 2022, section 62J.61, subdivision 5, is amended to read:

1.20 Subd. 5. ~~Biennial review of rulemaking procedures and rules~~ Opportunity for

1.21 comment. The commissioner shall ~~biennially seek comments from affected parties~~ maintain

1.22 an email address for submission of comments from interested parties to provide input about

1.23 the effectiveness of and continued need for the rulemaking procedures set out in subdivision

1.24 2 and about the quality and effectiveness of rules adopted using these procedures. The

1.25 commissioner shall seek comments by holding a meeting and by publishing a notice in the

1.26 State Register that contains the date, time, and location of the meeting and a statement that

1.27 invites oral or written comments. The notice must be published at least 30 days before the

1.28 meeting date. The commissioner shall write a report summarizing the comments and shall

1.29 submit the report to the Minnesota Health Data Institute and to the Minnesota Administrative

2.1 ~~Uniformity Committee by January 15 of every even-numbered year~~ may seek additional  
2.2 input and provide additional opportunities for input as needed.

2.3 Sec. 2. Minnesota Statutes 2023 Supplement, section 144.0526, subdivision 1, is amended  
2.4 to read:

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

2.8 Sec. 3. Minnesota Statutes 2022, section 144.058, is amended to read:

2.9 **144.058 INTERPRETER SERVICES QUALITY INITIATIVE.**

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

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

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

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

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

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

2.24 (iii) recommendations for appropriate fees; and

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

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

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

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

3.7 Sec. 4. Minnesota Statutes 2022, section 144.0724, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

3.30 ~~(h)~~ (g) "Nursing facility level of care determination" means the assessment process that  
3.31 results in a determination of a resident's or prospective resident's need for nursing facility

4.1 level of care as established in subdivision 11 for purposes of medical assistance payment  
4.2 of long-term care services for:

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

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

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

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

4.7 Sec. 5. Minnesota Statutes 2022, section 144.0724, subdivision 3a, is amended to read:

4.8 Subd. 3a. **Resident reimbursement case mix classifications beginning January 1,**  
4.9 **2012.** (a) ~~Beginning January 1, 2012,~~ Resident reimbursement case mix classifications shall  
4.10 be based on the Minimum Data Set, version 3.0 assessment instrument, or its successor  
4.11 version mandated by the Centers for Medicare and Medicaid Services that nursing facilities  
4.12 are required to complete for all residents. ~~The commissioner of health shall establish resident~~  
4.13 ~~classifications according to the RUG-IV, 48 group, resource utilization groups. Resident~~  
4.14 ~~classification must be established based on the individual items on the Minimum Data Set,~~  
4.15 ~~which must be completed according to the Long Term Care Facility Resident Assessment~~  
4.16 ~~Instrument User's Manual Version 3.0 or its successor issued by the Centers for Medicare~~  
4.17 ~~and Medicaid Services. Case mix classifications shall also be based on assessments required~~  
4.18 under subdivision 4. Assessments must be completed according to the Long Term Care  
4.19 Facility Resident Assessment Instrument User's Manual Version 3.0 or a successor manual  
4.20 issued by the Centers for Medicare and Medicaid Services. The optional state assessment  
4.21 must be completed according to the OSA Manual Version 1.0 v.2.

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

4.25 Sec. 6. Minnesota Statutes 2022, section 144.0724, subdivision 4, is amended to read:

4.26 Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically  
4.27 submit to the federal database MDS assessments that conform with the assessment schedule  
4.28 defined by the Long Term Care Facility Resident Assessment Instrument User's Manual,  
4.29 version 3.0, or its successor issued by the Centers for Medicare and Medicaid Services. The  
4.30 commissioner of health may substitute successor manuals or question and answer documents  
4.31 published by the United States Department of Health and Human Services, Centers for

5.1 Medicare and Medicaid Services, to replace or supplement the current version of the manual  
5.2 or document.

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

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

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

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

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

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

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

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

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

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

5.30 (8) (7) any modifications to the most recent assessments under clauses (1) to ~~(7)~~ (6).

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

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

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

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

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

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

6.18 Sec. 7. Minnesota Statutes 2022, section 144.0724, subdivision 6, is amended to read:

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

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

7.1 commissioner of human services, limit the penalty for residents covered by medical assistance  
7.2 to ten days.

7.3 Sec. 8. Minnesota Statutes 2022, section 144.0724, subdivision 7, is amended to read:

7.4 Subd. 7. **Notice of resident reimbursement case mix classification.** (a) The  
7.5 commissioner of health shall provide to a nursing facility a notice for each resident of the  
7.6 classification established under subdivision 1. The notice must inform the resident of the  
7.7 case mix classification assigned, the opportunity to review the documentation supporting  
7.8 the classification, the opportunity to obtain clarification from the commissioner, and the  
7.9 opportunity to request a reconsideration of the classification and the address and telephone  
7.10 number of the Office of Ombudsman for Long-Term Care. The commissioner must transmit  
7.11 the notice of resident classification by electronic means to the nursing facility. The nursing  
7.12 facility is responsible for the distribution of the notice to each resident or the resident's  
7.13 representative. This notice must be distributed within three business days after the facility's  
7.14 receipt.

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

7.20 Sec. 9. Minnesota Statutes 2022, section 144.0724, subdivision 8, is amended to read:

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

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

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

7.30 (2) Within three business days of receiving the reconsideration request, the nursing  
7.31 facility must submit to the commissioner of health a completed reconsideration request  
7.32 form, a copy of the resident's or resident's representative's written request, and all supporting

8.1 documentation used to complete the assessment being considered. If the facility fails to  
8.2 provide the required information, the reconsideration will be completed with the information  
8.3 submitted and the facility cannot make further reconsideration requests on this classification.

8.4 (3) Upon written request and within three business days, the nursing facility must give  
8.5 the resident or the resident's representative a copy of the assessment being reconsidered and  
8.6 all supporting documentation used to complete the assessment. Notwithstanding any law  
8.7 to the contrary, the facility may not charge a fee for providing copies of the requested  
8.8 documentation. If a facility fails to provide the required documents within this time, it is  
8.9 subject to the issuance of a correction order and penalty assessment under sections 144.653  
8.10 and 144A.10. Notwithstanding those sections, any correction order issued under this  
8.11 subdivision must require that the nursing facility immediately comply with the request for  
8.12 information, and as of the date of the issuance of the correction order, the facility shall  
8.13 forfeit to the state a \$100 fine for the first day of noncompliance, and an increase in the  
8.14 \$100 fine by \$50 increments for each day the noncompliance continues.

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

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

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

8.20 (ii) of the potential for a classification and subsequent rate change;

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

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

8.23 and

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

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

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



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

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

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

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

9.28 Sec. 10. Minnesota Statutes 2022, section 144.0724, subdivision 9, is amended to read:

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

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

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

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

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

10.10 (1) Each facility shall be audited annually. If a facility has two successive audits in which  
10.11 the percentage of change is five percent or less and the facility has not been the subject of  
10.12 a special audit in the past 36 months, the facility may be audited biannually. A stratified  
10.13 sample of 15 percent, with a minimum of ten assessments, of the most current assessments  
10.14 shall be selected for audit. If more than 20 percent of the ~~RUG-IV~~ reimbursement  
10.15 classifications are changed as a result of the audit, the audit shall be expanded to a second  
10.16 15 percent sample, with a minimum of ten assessments. If the total change between the first  
10.17 and second samples is 35 percent or greater, the commissioner may expand the audit to all  
10.18 of the remaining assessments.

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

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

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

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

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

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

10.30 (v) a criminal indictment alleging provider fraud;

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

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

11.1 (viii) nonsubmission of assessments;

11.2 (ix) late submission of assessments; or

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

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

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

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

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

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

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

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

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

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

11.28 (7) the person is determined to be at risk for nursing facility admission or readmission  
11.29 through a face-to-face long-term care consultation assessment as specified in section  
11.30 256B.0911, subdivision 17 to 21, 23, 24, 27, or 28, by a county, tribe, or managed care  
11.31 organization under contract with the Department of Human Services. The person is

12.1 considered at risk under this clause if the person currently lives alone or will live alone or  
12.2 be homeless without the person's current housing and also meets one of the following criteria:

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

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

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

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

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

12.20 Sec. 12. Minnesota Statutes 2022, section 144.1911, subdivision 2, is amended to read:

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

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

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

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

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

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

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

13.10 Sec. 13. Minnesota Statutes 2022, section 144.605, is amended by adding a subdivision  
13.11 to read:

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

13.15 Sec. 14. Minnesota Statutes 2022, section 144A.10, subdivision 15, is amended to read:

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

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

13.25 Sec. 15. Minnesota Statutes 2022, section 144A.10, subdivision 16, is amended to read:

13.26 Subd. 16. **Independent informal dispute resolution.** (a) Notwithstanding subdivision  
13.27 15, a facility certified under the federal Medicare or Medicaid programs that has been  
13.28 assessed a civil money penalty as provided by Code of Federal Regulations, title 42, section  
13.29 488.430, may request from the commissioner, in writing, an independent informal dispute  
13.30 resolution process regarding any deficiency ~~citation issued to the facility.~~  
13.31 ~~specify in its written request each deficiency citation that it disputes.~~ The commissioner  
13.32 ~~shall provide a hearing under sections 14.57 to 14.62. Upon the written request of the facility,~~

14.1 ~~the parties must submit the issues raised to arbitration by an administrative law judge~~ submit  
14.2 its request in writing within ten calendar days of receiving notice that a civil money penalty  
14.3 will be imposed.

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

14.6 (c) An independent informal dispute resolution may not be requested for any deficiency  
14.7 that is the subject of an active informal dispute resolution requested under subdivision 15.  
14.8 The facility must withdraw its informal dispute resolution prior to requesting independent  
14.9 informal dispute resolution.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15.27 **EFFECTIVE DATE.** This section is effective October 1, 2024, or upon federal approval,  
 15.28 whichever is later, and applies to appeals of deficiencies which are issued after October 1,  
 15.29 2024, or on or after the date upon which federal approval is obtained, whichever is later.  
 15.30 The commissioner of health shall notify the revisor of statutes when federal approval is  
 15.31 obtained.

16.1 Sec. 16. Minnesota Statutes 2022, section 144A.44, subdivision 1, is amended to read:

16.2 Subdivision 1. **Statement of rights.** (a) A client who receives home care services ~~in the~~  
16.3 ~~community or in an assisted-living facility licensed under chapter 144G~~ has these rights:

16.4 (1) receive written information, in plain language, about rights before receiving services,  
16.5 including what to do if rights are violated;

16.6 (2) receive care and services according to a suitable and up-to-date plan, and subject to  
16.7 accepted health care, medical or nursing standards and person-centered care, to take an  
16.8 active part in developing, modifying, and evaluating the plan and services;

16.9 (3) be told before receiving services the type and disciplines of staff who will be providing  
16.10 the services, the frequency of visits proposed to be furnished, other choices that are available  
16.11 for addressing home care needs, and the potential consequences of refusing these services;

16.12 (4) be told in advance of any recommended changes by the provider in the service plan  
16.13 and to take an active part in any decisions about changes to the service plan;

16.14 (5) refuse services or treatment;

16.15 (6) know, before receiving services or during the initial visit, any limits to the services  
16.16 available from a home care provider;

16.17 (7) be told before services are initiated what the provider charges for the services; to  
16.18 what extent payment may be expected from health insurance, public programs, or other  
16.19 sources, if known; and what charges the client may be responsible for paying;

16.20 (8) know that there may be other services available in the community, including other  
16.21 home care services and providers, and to know where to find information about these  
16.22 services;

16.23 (9) choose freely among available providers and to change providers after services have  
16.24 begun, within the limits of health insurance, long-term care insurance, medical assistance,  
16.25 other health programs, or public programs;

16.26 (10) have personal, financial, and medical information kept private, and to be advised  
16.27 of the provider's policies and procedures regarding disclosure of such information;

16.28 (11) access the client's own records and written information from those records in  
16.29 accordance with sections 144.291 to 144.298;

16.30 (12) be served by people who are properly trained and competent to perform their duties;



17.1 (13) be treated with courtesy and respect, and to have the client's property treated with  
17.2 respect;

17.3 (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms  
17.4 of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors  
17.5 Act;

17.6 (15) reasonable, advance notice of changes in services or charges;

17.7 (16) know the provider's reason for termination of services;

17.8 (17) at least ten calendar days' advance notice of the termination of a service by a home  
17.9 care provider; ~~except at least 30 calendar days' advance notice of the service termination~~  
17.10 ~~shall be given by a home care provider for services provided to a client residing in an assisted~~  
17.11 ~~living facility as defined in section 144G.08, subdivision 7. This clause does not apply in~~  
17.12 cases where:

17.13 (i) the client engages in conduct that significantly alters the terms of the service plan  
17.14 with the home care provider;

17.15 (ii) the client, person who lives with the client, or others create an abusive or unsafe  
17.16 work environment for the person providing home care services; or

17.17 (iii) an emergency or a significant change in the client's condition has resulted in service  
17.18 needs that exceed the current service plan and that cannot be safely met by the home care  
17.19 provider;

17.20 (18) a coordinated transfer when there will be a change in the provider of services;

17.21 (19) complain to staff and others of the client's choice about services that are provided,  
17.22 or fail to be provided, and the lack of courtesy or respect to the client or the client's property  
17.23 and the right to recommend changes in policies and services, free from retaliation including  
17.24 the threat of termination of services;

17.25 (20) know how to contact an individual associated with the home care provider who is  
17.26 responsible for handling problems and to have the home care provider investigate and  
17.27 attempt to resolve the grievance or complaint;

17.28 (21) know the name and address of the state or county agency to contact for additional  
17.29 information or assistance; and

17.30 (22) assert these rights personally, or have them asserted by the client's representative  
17.31 or by anyone on behalf of the client, without retaliation; ~~and.~~

18.1 ~~(23) place an electronic monitoring device in the client's or resident's space in compliance~~  
 18.2 ~~with state requirements.~~

18.3 (b) When providers violate the rights in this section, they are subject to the fines and  
 18.4 license actions in sections 144A.474, subdivision 11, and 144A.475.

18.5 (c) Providers must do all of the following:

18.6 (1) encourage and assist in the fullest possible exercise of these rights;

18.7 (2) provide the names and telephone numbers of individuals and organizations that  
 18.8 provide advocacy and legal services for clients ~~and residents~~ seeking to assert their rights;

18.9 (3) make every effort to assist clients ~~or residents~~ in obtaining information regarding  
 18.10 whether Medicare, medical assistance, other health programs, or public programs will pay  
 18.11 for services;

18.12 (4) make reasonable accommodations for people who have communication disabilities,  
 18.13 or those who speak a language other than English; and

18.14 (5) provide all information and notices in plain language and in terms the client ~~or~~  
 18.15 ~~resident~~ can understand.

18.16 (d) No provider may require or request a client ~~or resident~~ to waive any of the rights  
 18.17 listed in this section at any time or for any reasons, including as a condition of initiating  
 18.18 services ~~or entering into an assisted living contract.~~

18.19 Sec. 17. Minnesota Statutes 2022, section 144A.471, is amended by adding a subdivision  
 18.20 to read:

18.21 Subd. 1a. **Licensure under other law.** A home care licensee must not provide sleeping  
 18.22 accommodations as a provision of home care services. For purposes of this subdivision, the  
 18.23 provision of sleeping accommodations and assisted living services under section 144G.08,  
 18.24 subdivision 9, requires assisted living licensure under chapter 144G.

18.25 Sec. 18. Minnesota Statutes 2022, section 144A.474, subdivision 13, is amended to read:

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

18.28 (1) Minnesota home care licensure requirements;

18.29 (2) Minnesota home care bill of rights;

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

- 19.1 (4) principles of documentation;
- 19.2 (5) survey protocol and processes;
- 19.3 (6) Offices of the Ombudsman roles;
- 19.4 (7) Office of Health Facility Complaints;
- 19.5 (8) Minnesota landlord-tenant ~~and housing with services~~ laws;
- 19.6 (9) types of payors for home care services; and
- 19.7 (10) Minnesota Nurse Practice Act for nurse surveyors.

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

19.11 Sec. 19. Minnesota Statutes 2023 Supplement, section 144A.4791, subdivision 10, is  
19.12 amended to read:

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

19.17 (1) the effective date of termination;

19.18 (2) the reason for termination;

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

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

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

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

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

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

20.4 Sec. 20. Minnesota Statutes 2022, section 144G.08, subdivision 29, is amended to read:

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

20.11 Sec. 21. Minnesota Statutes 2022, section 144G.10, is amended by adding a subdivision  
20.12 to read:

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

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

20.23 Sec. 22. Minnesota Statutes 2022, section 144G.16, subdivision 6, is amended to read:

20.24 Subd. 6. **Requirements for notice and transfer.** A provisional licensee whose license  
20.25 is denied must comply with the requirements for notification and the coordinated move of  
20.26 residents in sections 144G.52 and 144G.55. If the license denial is upheld by the  
20.27 reconsideration process, the licensee must submit a closure plan as required by section  
20.28 144G.57 within ten calendar days of receipt of the reconsideration decision.

20.29 Sec. 23. Minnesota Statutes 2022, section 146B.03, subdivision 7a, is amended to read:

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

21.1 (1) two years as a tattoo technician licensed under section 146B.03, subdivision 4, 6, or  
21.2 8, in order to supervise a temporary tattoo technician; or

21.3 (2) one year as a body piercing technician licensed under section 146B.03, subdivision  
21.4 4, 6, or 8, or must have performed at least 500 body piercings, in order to supervise a  
21.5 temporary body piercing technician.

21.6 (b) Any technician who agrees to supervise more than two temporary tattoo technicians  
21.7 during the same time period, or more than four body piercing technicians during the same  
21.8 time period, must provide to the commissioner a supervisory plan that describes how the  
21.9 technician will provide supervision to each temporary technician in accordance with section  
21.10 146B.01, subdivision 28.

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

21.12 (1) the areas of practice under supervision;

21.13 (2) the anticipated supervision hours per week;

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

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

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

21.20 (e) The commissioner may refuse to approve as a supervisor a technician who has been  
21.21 disciplined in Minnesota or in another jurisdiction after considering the criteria in section  
21.22 146B.02, subdivision 10, paragraph (b).

21.23 Sec. 24. Minnesota Statutes 2022, section 146B.10, subdivision 1, is amended to read:

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

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

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

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

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

22.1 (f) The fee for an initial establishment license application and the two-year license  
 22.2 renewal period application required in section 146B.02, subdivision 2, paragraph (b), is  
 22.3 \$1,500.

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

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

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

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

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

22.15 Sec. 25. Minnesota Statutes 2022, section 146B.10, subdivision 3, is amended to read:

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

22.18 Sec. 26. Minnesota Statutes 2022, section 149A.65, is amended to read:

22.19 **149A.65 FEES.**

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

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

22.24 (1) \$75 for the initial and renewal registration of a mortuary science intern;

22.25 (2) \$125 for the mortuary science examination;

22.26 (3) \$200 for ~~issuance of~~ initial and renewal mortuary science ~~licenses~~ license applications;

22.27 (4) \$100 late fee charge for a license renewal application; and

22.28 (5) \$250 for ~~issuing a~~ an application for mortuary science license by endorsement.

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

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

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

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

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

23.12 Sec. 27. Minnesota Statutes 2022, section 152.22, is amended by adding a subdivision to  
23.13 read:

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

23.16 Sec. 28. Minnesota Statutes 2022, section 152.25, subdivision 2, is amended to read:

23.17 Subd. 2. **Range of compounds and dosages; report.** The commissioner shall review  
23.18 and publicly report the existing medical and scientific literature regarding the range of  
23.19 recommended dosages for each qualifying condition and the range of chemical compositions  
23.20 of any plant of the genus cannabis that will likely be medically beneficial for each of the  
23.21 qualifying medical conditions. The commissioner shall make this information available to  
23.22 patients with qualifying medical conditions beginning December 1, 2014, and update the  
23.23 information ~~annually~~ every three years. The commissioner may consult with the independent  
23.24 laboratory under contract with the manufacturer or other experts in reporting the range of  
23.25 recommended dosages for each qualifying medical condition, the range of chemical  
23.26 compositions that will likely be medically beneficial, and any risks of noncannabis drug  
23.27 interactions. The commissioner shall consult with each manufacturer on an annual basis on  
23.28 medical cannabis offered by the manufacturer. The list of medical cannabis offered by a  
23.29 manufacturer shall be published on the Department of Health website.

24.1 Sec. 29. Minnesota Statutes 2022, section 152.27, is amended by adding a subdivision to  
24.2 read:

24.3 Subd. 3a. **Application procedure for veterans.** (a) Beginning July 1, 2024, the  
24.4 commissioner shall establish an alternative certification procedure for veterans to confirm  
24.5 that the veteran has been diagnosed with a qualifying medical condition.

24.6 (b) A patient who is also a veteran and is seeking to enroll in the registry program must  
24.7 submit a copy of the patient's veteran health identification card issued by the United States  
24.8 Department of Veterans Affairs and an application established by the commissioner to  
24.9 certify that the patient has been diagnosed with a qualifying medical condition.

24.10 Sec. 30. Minnesota Statutes 2022, section 152.27, subdivision 6, is amended to read:

24.11 **Subd. 6. Patient enrollment.** (a) After receipt of a patient's application, application fees,  
24.12 and signed disclosure, the commissioner shall enroll the patient in the registry program and  
24.13 issue the patient and patient's registered designated caregiver or parent, legal guardian, or  
24.14 spouse, if applicable, a registry verification. The commissioner shall approve or deny a  
24.15 patient's application for participation in the registry program within 30 days after the  
24.16 commissioner receives the patient's application and application fee. The commissioner may  
24.17 approve applications up to 60 days after the receipt of a patient's application and application  
24.18 fees until January 1, 2016. A patient's enrollment in the registry program shall only be  
24.19 denied if the patient:

24.20 (1) does not have certification from a health care practitioner, or if the patient is a veteran  
24.21 receiving care from the United States Department of Veterans Affairs, the documentation  
24.22 required under subdivision 3a, that the patient has been diagnosed with a qualifying medical  
24.23 condition;

24.24 (2) has not signed and returned the disclosure form required under subdivision 3,  
24.25 paragraph (c), to the commissioner;

24.26 (3) does not provide the information required;

24.27 (4) has previously been removed from the registry program for violations of section  
24.28 152.30 or 152.33; or

24.29 (5) provides false information.

24.30 (b) The commissioner shall give written notice to a patient of the reason for denying  
24.31 enrollment in the registry program.



25.1 (c) Denial of enrollment into the registry program is considered a final decision of the  
25.2 commissioner and is subject to judicial review under the Administrative Procedure Act  
25.3 pursuant to chapter 14.

25.4 (d) A patient's enrollment in the registry program may only be revoked upon the death  
25.5 of the patient or if a patient violates a requirement under section 152.30 or 152.33.

25.6 (e) The commissioner shall develop a registry verification to provide to the patient, the  
25.7 health care practitioner identified in the patient's application, and to the manufacturer. The  
25.8 registry verification shall include:

25.9 (1) the patient's name and date of birth;

25.10 (2) the patient registry number assigned to the patient; and

25.11 (3) the name and date of birth of the patient's registered designated caregiver, if any, or  
25.12 the name of the patient's parent, legal guardian, or spouse if the parent, legal guardian, or  
25.13 spouse will be acting as a caregiver.

25.14 Sec. 31. Minnesota Statutes 2023 Supplement, section 152.28, subdivision 1, is amended  
25.15 to read:

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

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

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

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

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

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

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

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

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

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

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

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

26.14 Sec. 32. Minnesota Statutes 2023 Supplement, section 342.54, subdivision 2, is amended  
26.15 to read:

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

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

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

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

26.27 (4) review and publicly report on existing medical and scientific literature regarding the  
26.28 range of recommended dosages for each qualifying medical condition, the range of chemical  
26.29 compositions of medical cannabis flower and medical cannabinoid products that will likely  
26.30 be medically beneficial for each qualifying medical condition, and any risks of noncannabis  
26.31 drug interactions. This information must be updated by December 1 ~~of each year~~ every three

27.1 years. The office may consult with an independent laboratory under contract with the office  
 27.2 or other experts in reporting and updating this information; and

27.3 (5) annually consult with cannabis businesses about medical cannabis that the businesses  
 27.4 cultivate, manufacture, and offer for sale and post on the Division of Medical Cannabis  
 27.5 website a list of the medical cannabis flower and medical cannabinoid products offered for  
 27.6 sale by each medical cannabis retailer.

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

27.8 Sec. 33. Minnesota Statutes 2023 Supplement, section 342.55, subdivision 2, is amended  
 27.9 to read:

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

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

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

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

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

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

27.25 Sec. 34. **REVISOR INSTRUCTION.**

27.26 The revisor of statutes shall substitute the term "employee" with the term "staff" in the  
 27.27 following sections of Minnesota Statutes and make any grammatical changes needed without  
 27.28 changing the meaning of the sentence: Minnesota Statutes, sections 144G.08, subdivisions  
 27.29 18 and 36; 144G.13, subdivision 1, paragraph (c); 144G.20, subdivisions 1, 2, and 21;  
 27.30 144G.30, subdivision 5; 144G.42, subdivision 8; 144G.45, subdivision 2; 144G.60,  
 27.31 subdivisions 1, paragraph (c), and 3, paragraph (a); 144G.63, subdivision 2, paragraph (a),

28.1 clause (9); 144G.64, paragraphs (a), clauses (2), (3), and (5), and (c); 144G.70, subdivision  
28.2 7; and 144G.92, subdivisions 1 and 3.

28.3 Sec. 35. **REPEALER.**

28.4 Minnesota Statutes 2022, section 144.497, is repealed.

**144.497 ST ELEVATION MYOCARDIAL INFARCTION.**

The commissioner of health shall assess and report on the quality of care provided in the state for ST elevation myocardial infarction response and treatment. The commissioner shall:

(1) utilize and analyze data provided by ST elevation myocardial infarction receiving centers to the ACTION Registry-Get with the guidelines or an equivalent data platform that does not identify individuals or associate specific ST elevation myocardial infarction heart attack events with an identifiable individual;

(2) annually post a summary report of the data in aggregate form on the Department of Health website; and

(3) coordinate to the extent possible with national voluntary health organizations involved in ST elevation myocardial infarction heart attack quality improvement to encourage ST elevation myocardial infarction receiving centers to report data consistent with nationally recognized guidelines on the treatment of individuals with confirmed ST elevation myocardial infarction heart attacks within the state and encourage sharing of information among health care providers on ways to improve the quality of care of ST elevation myocardial infarction patients in Minnesota.