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
03/14/2024	12220a	Comm report: To pass as amended and re-refer to Human Services

A bill for an act

relating to health; changing provisions for public review process in rulemaking, case mix review, and Minnesota One Health Antimicrobial Stewardship Collaborative; modifying a definition; creating a waiver for procurement contractors; aligning independent informal dispute resolution process; modifying licensure requirements for assisted living and home care licensure, and body art technicians and body art establishments; modifying medical cannabis provisions; amending Minnesota Statutes 2022, sections 62J.61, subdivision 5; 144.058; 144.0724, subdivisions 2, 3a, 4, 6, 7, 8, 9, 11; 144.1911, subdivision 2; 144.605, by adding a subdivision; 144A.10, subdivisions 15, 16; 144A.44, subdivision 1; 144A.471, by adding a subdivision; 144A.474, subdivision 13; 144G.08, subdivision 29; 144G.10, by adding a subdivision; 144G.16, subdivision 6; 146B.03, subdivision 7a; 146B.10, subdivisions 1, 3; 149A.65; 152.22, by adding a subdivision; 152.25, subdivision 2; 152.27, subdivision 6, by adding a subdivision; 256R.02, subdivision 20; Minnesota Statutes 2023 Supplement, sections 144.0526, subdivision 1; 144A.4791, subdivision 10; 152.28, subdivision 1; 342.54, subdivision 2; 342.55, subdivision 2; repealing Minnesota Statutes 2022, sections 144.497; 256R.02, subdivision 46.

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

Section 1. 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. 2. 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. 3. 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. 4. 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. 5. 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. 6. 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. 7. 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. 8. 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. 9. 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 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. 10. 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. 11. 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. 12. 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. 13. 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. 14. 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. 15. 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 (c), 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.

~~(e)~~ (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. 16. Minnesota Statutes 2022, section 144A.44, subdivision 1, is amended to read:

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

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

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

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

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

(5) refuse services or treatment;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Providers must do all of the following:

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

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

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

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

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

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

Sec. 17. 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.

Sec. 18. 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. 19. 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. 20. 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. 21. 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. 22. 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 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. 24. 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. 25. 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. 26. 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. 27. 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. 28. 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 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. 29. Minnesota Statutes 2022, section 152.27, is amended by adding a subdivision to read:

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

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

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

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

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

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

(3) does not provide the information required;

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

(5) provides false information.

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

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

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

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

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

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

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

Sec. 31. 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. 32. 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. 33. 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. 34. 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. 35. **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. 36. **REPEALER.**

Minnesota Statutes 2022, sections 144.497; and 256R.02, subdivision 46, are 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.

256R.02 DEFINITIONS.

Subd. 46. **Resource utilization group.** "Resource utilization groups" or "RUG" has the meaning given in section 144.0724, subdivision 2, paragraph (f).