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State of Minnesota

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HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 4467

03/18/2026 Authored by Bierman and Repinski
The bill was read for the first time and referred to the Committee on Health Finance and Policy
03/26/2026 Adoption of Report: Placed on the General Register as Amended
Read for the Second Time

1.1 A bill for an act

1.2 relating to human services; modifying provider disenrollment, premium payment
1.3 requirements, and physician-directed clinic staff services coverage; modifying
1.4 enrollment for the county-administered rural medical assistance program;
1.5 recodifying certain language; requiring a report; amending Minnesota Statutes
1.6 2024, sections 142B.01, subdivision 8; 245A.02, subdivision 5a; 245D.081,
1.7 subdivision 3; 256B.057, subdivision 9; 256B.0625, subdivision 4; 256B.0949,
1.8 subdivision 17; 256L.05, subdivision 3; 256L.06, subdivision 3; Minnesota Statutes
1.9 2025 Supplement, sections 256B.04, subdivision 21; 256B.0759, subdivision 4;
1.10 256B.0949, subdivision 16; 256B.695, subdivision 5; Laws 2024, chapter 125,
1.11 article 4, section 12, subdivision 5; proposing coding for new law in Minnesota
1.12 Statutes, chapter 256B.

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

1.14 Section 1. Minnesota Statutes 2024, section 142B.01, subdivision 8, is amended to read:

1.15 Subd. 8. **Controlling individual.** (a) "Controlling individual" means an owner of a
1.16 program or service provider licensed under this chapter and the following individuals, if
1.17 applicable:

1.18 (1) each officer of the organization, including the chief executive officer and chief
1.19 financial officer;

1.20 (2) the individual designated as the authorized agent under section 142B.10, subdivision
1.21 1, paragraph (b);

1.22 (3) the individual designated as the compliance officer under section ~~256B.04, subdivision~~
1.23 ~~21, paragraph (g)~~ 256B.044, subdivision 7, paragraph (b);

1.24 (4) each managerial official whose responsibilities include the direction of the
1.25 management or policies of a program;

2.1 (5) the individual designated as the primary provider of care for a special family child
2.2 care program under section 142B.41, subdivision 4, paragraph (d); and

2.3 (6) the president and treasurer of the board of directors of a nonprofit corporation.

2.4 (b) Controlling individual does not include:

2.5 (1) a bank, savings bank, trust company, savings association, credit union, industrial
2.6 loan and thrift company, investment banking firm, or insurance company unless the entity
2.7 operates a program directly or through a subsidiary;

2.8 (2) an individual who is a state or federal official, or state or federal employee, or a
2.9 member or employee of the governing body of a political subdivision of the state or federal
2.10 government that operates one or more programs, unless the individual is also an officer,
2.11 owner, or managerial official of the program; receives remuneration from the program; or
2.12 owns any of the beneficial interests not excluded in this subdivision;

2.13 (3) an individual who owns less than five percent of the outstanding common shares of
2.14 a corporation:

2.15 (i) whose securities are exempt under section 80A.45, clause (6); or

2.16 (ii) whose transactions are exempt under section 80A.46, clause (2);

2.17 (4) an individual who is a member of an organization exempt from taxation under section
2.18 290.05, unless the individual is also an officer, owner, or managerial official of the program
2.19 or owns any of the beneficial interests not excluded in this subdivision. This clause does
2.20 not exclude from the definition of controlling individual an organization that is exempt from
2.21 taxation; or

2.22 (5) an employee stock ownership plan trust, or a participant or board member of an
2.23 employee stock ownership plan, unless the participant or board member is a controlling
2.24 individual according to paragraph (a).

2.25 (c) For purposes of this subdivision, "managerial official" means an individual who has
2.26 the decision-making authority related to the operation of the program, and the responsibility
2.27 for the ongoing management of or direction of the policies, services, or employees of the
2.28 program. A site director who has no ownership interest in the program is not considered to
2.29 be a managerial official for purposes of this definition.

3.1 Sec. 2. Minnesota Statutes 2024, section 245A.02, subdivision 5a, is amended to read:

3.2 Subd. 5a. **Controlling individual.** (a) "Controlling individual" means an owner of a
3.3 program or service provider licensed under this chapter and the following individuals, if
3.4 applicable:

3.5 (1) each officer of the organization, including the chief executive officer and chief
3.6 financial officer;

3.7 (2) the individual designated as the authorized agent under section 245A.04, subdivision
3.8 1, paragraph (b);

3.9 (3) the individual designated as the compliance officer under section ~~256B.04, subdivision~~
3.10 ~~21, paragraph (g)~~ 256B.044, subdivision 7, paragraph (b);

3.11 (4) each managerial official whose responsibilities include the direction of the
3.12 management or policies of a program; and

3.13 (5) the president and treasurer of the board of directors of a nonprofit corporation.

3.14 (b) Controlling individual does not include:

3.15 (1) a bank, savings bank, trust company, savings association, credit union, industrial
3.16 loan and thrift company, investment banking firm, or insurance company unless the entity
3.17 operates a program directly or through a subsidiary;

3.18 (2) an individual who is a state or federal official, or state or federal employee, or a
3.19 member or employee of the governing body of a political subdivision of the state or federal
3.20 government that operates one or more programs, unless the individual is also an officer,
3.21 owner, or managerial official of the program, receives remuneration from the program, or
3.22 owns any of the beneficial interests not excluded in this subdivision;

3.23 (3) an individual who owns less than five percent of the outstanding common shares of
3.24 a corporation:

3.25 (i) whose securities are exempt under section 80A.45, clause (6); or

3.26 (ii) whose transactions are exempt under section 80A.46, clause (2);

3.27 (4) an individual who is a member of an organization exempt from taxation under section
3.28 290.05, unless the individual is also an officer, owner, or managerial official of the program
3.29 or owns any of the beneficial interests not excluded in this subdivision. This clause does
3.30 not exclude from the definition of controlling individual an organization that is exempt from
3.31 taxation; or

(5) an employee stock ownership plan trust, or a participant or board member of an employee stock ownership plan, unless the participant or board member is a controlling individual according to paragraph (a).

(c) For purposes of this subdivision, "managerial official" means an individual who has the decision-making authority related to the operation of the program, and the responsibility for the ongoing management of or direction of the policies, services, or employees of the program. A site director who has no ownership interest in the program is not considered to be a managerial official for purposes of this definition.

Sec. 3. Minnesota Statutes 2024, section 245D.081, subdivision 3, is amended to read:

Subd. 3. **Program management and oversight.** (a) The license holder must designate a managerial staff person or persons to provide program management and oversight of the services provided by the license holder. The designated manager is responsible for the following:

(1) maintaining a current understanding of the licensing requirements sufficient to ensure compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph (e), and when applicable, as identified in section ~~256B.04, subdivision 21, paragraph (g)~~ 256B.044, subdivision 7;

(2) ensuring the duties of the designated coordinator are fulfilled according to the requirements in subdivision 2;

(3) ensuring the program implements corrective action identified as necessary by the program following review of incident and emergency reports according to the requirements in section 245D.11, subdivision 2, clause (7). An internal review of incident reports of alleged or suspected maltreatment must be conducted according to the requirements in section 245A.65, subdivision 1, paragraph (b);

(4) evaluation of satisfaction of persons served by the program, the person's legal representative, if any, and the case manager, with the service delivery and progress toward accomplishing outcomes identified in sections 245D.07 and 245D.071, and ensuring and protecting each person's rights as identified in section 245D.04;

(5) ensuring staff competency requirements are met according to the requirements in section 245D.09, subdivision 3, and ensuring staff orientation and training is provided according to the requirements in section 245D.09, subdivisions 4, 4a, and 5;

(6) ensuring corrective action is taken when ordered by the commissioner and that the terms and conditions of the license and any variances are met; and

(7) evaluating the information identified in clauses (1) to (6) to develop, document, and implement ongoing program improvements.

(b) The designated manager must be competent to perform the duties as required and must minimally meet the education and training requirements identified in subdivision 2, paragraph (b), and have a minimum of three years of supervisory level experience in a program that provides care or education to vulnerable adults or children.

Sec. 4. Minnesota Statutes 2025 Supplement, section 256B.04, subdivision 21, is amended to read:

Subd. 21. **Provider enrollment.** ~~(a)~~ The commissioner shall enroll providers and conduct screening activities as required by sections 256B.044 to 256B.0444 and Code of Federal Regulations, title 42, section 455, subpart E.

~~A provider must enroll each provider-controlled location where direct services are provided. The commissioner may deny a provider's incomplete application if a provider fails to respond to the commissioner's request for additional information within 60 days of the request. The commissioner must conduct a background study under chapter 245C, including a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5), for a provider described in this paragraph. The background study requirement may be satisfied if the commissioner conducted a fingerprint-based background study on the provider that includes a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5).~~

~~(b) The commissioner shall revalidate:~~

~~(1) each provider under this subdivision at least once every five years;~~

~~(2) each personal care assistance agency, CFSS provider-agency, and CFSS financial management services provider under this subdivision at least once every three years;~~

~~(3) each EIDBI agency under this subdivision at least once every three years; and~~

~~(4) at the commissioner's discretion, any medical-assistance-only provider type the commissioner deems "high-risk" under this subdivision.~~

~~(c) The commissioner shall conduct revalidation as follows:~~

~~(1) provide 30-day notice of the revalidation due date including instructions for revalidation and a list of materials the provider must submit;~~

~~(2) if a provider fails to submit all required materials by the due date, notify the provider of the deficiency within 30 days after the due date and allow the provider an additional 30 days from the notification date to comply; and~~

~~(3) if a provider fails to remedy a deficiency within the 30-day time period, give 60-day notice of termination and immediately suspend the provider's ability to bill. The provider does not have the right to appeal suspension of ability to bill.~~

~~(d) If a provider fails to comply with any individual provider requirement or condition of participation, the commissioner may suspend the provider's ability to bill until the provider comes into compliance. The commissioner's decision to suspend the provider is not subject to an administrative appeal.~~

~~(e) Correspondence and notifications, including notifications of termination and other actions, may be delivered electronically to a provider's MN-ITS mailbox. This paragraph does not apply to correspondences and notifications related to background studies.~~

~~(f) If the commissioner or the Centers for Medicare and Medicaid Services determines that a provider is designated "high-risk," the commissioner may withhold payment from providers within that category upon initial enrollment for a 90-day period. The withholding for each provider must begin on the date of the first submission of a claim.~~

~~(g) An enrolled provider that is also licensed by the commissioner under chapter 245A, is licensed as a home care provider by the Department of Health under chapter 144A, or is licensed as an assisted living facility under chapter 144G and has a home and community-based services designation on the home care license under section 144A.484, must designate an individual as the entity's compliance officer. The compliance officer must:~~

~~(1) develop policies and procedures to assure adherence to medical assistance laws and regulations and to prevent inappropriate claims submissions;~~

~~(2) train the employees of the provider entity, and any agents or subcontractors of the provider entity including billers, on the policies and procedures under clause (1);~~

~~(3) respond to allegations of improper conduct related to the provision or billing of medical assistance services, and implement action to remediate any resulting problems;~~

~~(4) use evaluation techniques to monitor compliance with medical assistance laws and regulations;~~

~~(5) promptly report to the commissioner any identified violations of medical assistance laws or regulations; and~~

~~(6) within 60 days of discovery by the provider of a medical assistance reimbursement overpayment, report the overpayment to the commissioner and make arrangements with the commissioner for the commissioner's recovery of the overpayment.~~

~~The commissioner may require, as a condition of enrollment in medical assistance, that a provider within a particular industry sector or category establish a compliance program that contains the core elements established by the Centers for Medicare and Medicaid Services.~~

~~(h) The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year, if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such provider, when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure to maintain documentation or provide access to documentation on more than one occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a provider under the provisions of section 256B.064.~~

~~(i) The commissioner shall terminate or deny the enrollment of any individual or entity if the individual or entity has been terminated from participation in Medicare or under the Medicaid program or Children's Health Insurance Program of any other state. The commissioner may exempt a rehabilitation agency from termination or denial that would otherwise be required under this paragraph, if the agency:~~

~~(1) is unable to retain Medicare certification and enrollment solely due to a lack of billing to the Medicare program;~~

~~(2) meets all other applicable Medicare certification requirements based on an on-site review completed by the commissioner of health; and~~

~~(3) serves primarily a pediatric population.~~

~~(j) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid Services, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location. The commissioner shall publish in the Minnesota Health Care Program Provider Manual a list of provider types designated "limited," "moderate," or "high-risk," based on the criteria and standards used to designate Medicare providers in Code of Federal Regulations, title~~

~~42, section 424.518. The list and criteria are not subject to the requirements of chapter 14. The commissioner's designations are not subject to administrative appeal.~~

~~(k) As a condition of enrollment in medical assistance, the commissioner shall require that a high-risk provider, or a person with a direct or indirect ownership interest in the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the commissioner or the Centers for Medicare and Medicaid Services that a provider is designated high-risk for fraud, waste, or abuse.~~

~~(l)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers meeting the durable medical equipment provider and supplier definition in clause (3), operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is annually renewed and designates the Minnesota Department of Human Services as the obligee, and must be submitted in a form approved by the commissioner. For purposes of this clause, the following medical suppliers are not required to obtain a surety bond: a federally qualified health center, a home health agency, the Indian Health Service, a pharmacy, and a rural health clinic.~~

~~(2) At the time of initial enrollment or reenrollment, durable medical equipment providers and suppliers defined in clause (3) must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions from a surety bond must occur within six years from the date the debt is affirmed by a final agency decision. An agency decision is final when the right to appeal the debt has been exhausted or the time to appeal has expired under section 256B.064.~~

~~(3) "Durable medical equipment provider or supplier" means a medical supplier that can purchase medical equipment or supplies for sale or rental to the general public and is able to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rental.~~

~~(m) The Department of Human Services may require a provider to purchase a surety bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the department determines~~

~~there is significant evidence of or potential for fraud and abuse by the provider, or (3) the provider or category of providers is designated high-risk pursuant to paragraph (f) and as per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in an amount of $100,000 or ten percent of the provider's payments from Medicaid during the immediately preceding 12 months, whichever is greater. The surety bond must name the Department of Human Services as an obligee and must allow for recovery of costs and fees in pursuing a claim on the bond. This paragraph does not apply if the provider currently maintains a surety bond under the requirements in section 256B.051, 256B.0659, 256B.0701, or 256B.85.~~

Sec. 5. **[256B.044] PROVIDER ENROLLMENT.**

Subdivision 1. **Designating categorical risk levels.** (a) The commissioner must designate provider types as "limited-risk," "moderate-risk," or "high-risk," based on the criteria and standards used to designate Medicare providers in Code of Federal Regulations, title 42, section 424.518. The commissioner must publish a list of provider types and designated categorical risk levels in the Minnesota Health Care Program Provider Manual.

(b) The list and criteria are not subject to the requirements of chapter 14, and section 14.386 does not apply.

(c) The commissioner's designations are not subject to administrative appeal.

Subd. 2. **Service location enrollment.** A provider must enroll each provider-controlled location where direct services are provided.

Subd. 3. **Incomplete provider enrollment applications.** The commissioner may deny a provider's incomplete enrollment application if a provider fails to respond to the commissioner's request for additional information within 60 days of the request.

Subd. 4. **Required background studies.** (a) The commissioner must conduct a background study under chapter 245C, including a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5), for a provider applying for enrollment under section 256B.04, subdivision 21. The background study requirement may be satisfied if the commissioner conducted a fingerprint-based background study on the provider that included a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5).

(b) As a condition of enrollment in medical assistance, the commissioner must require that a high-risk provider, or a person with a direct or indirect ownership interest in the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the

10.1 commissioner or the Centers for Medicare and Medicaid Services (CMS) that a provider is
10.2 designated high-risk.

10.3 Subd. 5. **Surety bonds.** (a) The commissioner may require a provider to purchase a
10.4 surety bond as a condition of initial enrollment, revalidation, reenrollment, reinstatement,
10.5 or continued enrollment if:

10.6 (1) the provider fails to demonstrate financial viability;

10.7 (2) the commissioner determines there is significant evidence of or potential for fraud
10.8 and abuse by the provider; or

10.9 (3) the provider or category of providers is designated high-risk pursuant to subdivision
10.10 1 and Code of Federal Regulations, title 42, section 455.450.

10.11 (b) The surety bond must be in an amount of $100,000 or ten percent of the provider's
10.12 payments from Medicaid during the immediately preceding 12 months, whichever is greater.
10.13 The surety bond must name the Department of Human Services as an obligee and must
10.14 allow for recovery of costs and fees in pursuing a claim on the bond.

10.15 (c) This subdivision does not apply if the provider currently maintains a surety bond
10.16 under the requirements in section 256B.051, 256B.0659, 256B.0701, or 256B.85.

10.17 Subd. 6. **Required permission to conduct on-site inspection.** As a condition of
10.18 enrollment in medical assistance, the commissioner shall require that a provider designated
10.19 moderate-risk or high-risk by CMS or the commissioner permit CMS, CMS's agents, or
10.20 CMS's designated contractors and the state agency, the state agency's agents, or the state
10.21 agency's designated contractors to conduct unannounced on-site inspections of any provider
10.22 location.

10.23 Subd. 7. **Compliance programs.** (a) The commissioner may require, as a condition of
10.24 enrollment in medical assistance, that a provider within a particular industry sector or
10.25 category establish a compliance program that contains the core elements established by
10.26 CMS.

10.27 (b) If an enrolled provider is required by the commissioner or by law to designate an
10.28 individual as the provider's compliance officer, the compliance officer must:

10.29 (1) develop policies and procedures to ensure adherence to medical assistance laws and
10.30 regulations and to prevent inappropriate claims submissions;

10.31 (2) train the employees of the provider entity and any agents or subcontractors of the
10.32 provider entity, including billers, on the policies and procedures under clause (1);

11.1 (3) respond to allegations of improper conduct related to the provision or billing of
11.2 medical assistance services and implement action to remediate any resulting problems;

11.3 (4) use evaluation techniques to monitor compliance with medical assistance laws and
11.4 regulations;

11.5 (5) promptly report to the commissioner any identified violations of medical assistance
11.6 laws or regulations; and

11.7 (6) within 60 days of discovery by the provider of a medical assistance reimbursement
11.8 overpayment, report the overpayment to the commissioner and make arrangements with
11.9 the commissioner for the commissioner's recovery of the overpayment.

11.10 Subd. 8. **Correspondence and notification.** The commissioner may deliver
11.11 correspondence and notifications, including notifications of termination and other actions,
11.12 electronically to a provider's MN-ITS mailbox. This subdivision does not apply to
11.13 correspondence and notifications related to background studies.

11.14 Sec. 6. **[256B.0441] PROVIDER REVALIDATION.**

11.15 Subdivision 1. **Provider revalidation schedule.** The commissioner shall revalidate:

11.16 (1) each provider at least once every five years;

11.17 (2) each personal care assistance agency, community first services and supports (CFSS)
11.18 agency-provider, and CFSS financial management services provider at least once every
11.19 three years;

11.20 (3) each early intensive developmental and behavioral intervention agency at least once
11.21 every three years; and

11.22 (4) at the commissioner's discretion, any medical-assistance-only provider type the
11.23 commissioner deems high-risk under section 256B.044, subdivision 1.

11.24 Subd. 2. **Revalidation procedures.** The commissioner shall conduct revalidation as
11.25 follows:

11.26 (1) provide 30 days' notice of the revalidation due date including instructions for
11.27 revalidation and a list of materials the provider must submit;

11.28 (2) if a provider fails to submit all required materials by the due date, notify the provider
11.29 of the deficiency within 30 days after the due date and allow the provider an additional 30
11.30 days from the notification date to comply; and

12.1 (3) if a provider fails to remedy a deficiency within the 30-day time period, give 60 days'
12.2 notice of termination and immediately suspend the provider's ability to bill. The provider
12.3 does not have the right to appeal suspension of ability to bill.

12.4 Sec. 7. **[256B.0442] PROVIDER ENROLLMENT SUSPENSIONS AND**
12.5 **TERMINATIONS.**

12.6 Subdivision 1. **Commissioner's general authority to suspend individual provider's**
12.7 **enrollment.** (a) If a provider fails to comply with any individual provider requirement or
12.8 condition of participation, the commissioner may suspend the provider's ability to bill until
12.9 the provider comes into compliance.

12.10 (b) The commissioner's decision to suspend the provider is not subject to an administrative
12.11 appeal.

12.12 Subd. 2. **Commissioner's authority to revoke enrollment of certain providers for**
12.13 **lack of documentation.** (a) The commissioner may revoke the enrollment of an ordering
12.14 or rendering provider for a period of not more than one year, if the provider fails to maintain
12.15 and, upon request from the commissioner, provide access to documentation relating to
12.16 written orders or requests for payment for durable medical equipment, certifications for
12.17 home health services, or referrals for other items or services written or ordered by the
12.18 provider, when the commissioner has identified a pattern of a lack of documentation. A
12.19 pattern means a failure to maintain documentation or provide access to documentation on
12.20 more than one occasion.

12.21 (b) Nothing in this subdivision limits the authority of the commissioner to sanction a
12.22 provider under section 256B.064.

12.23 Subd. 3. **Commissioner's duty to terminate provider enrollment.** (a) Except as
12.24 provided in paragraph (b), the commissioner must terminate or deny the enrollment of any
12.25 individual or entity if the individual or entity has been terminated from participation in
12.26 Medicare or under the Medicaid program or Children's Health Insurance Program of any
12.27 other state.

12.28 (b) The commissioner may exempt a rehabilitation agency from termination or denial
12.29 that would otherwise be required under paragraph (a), if the agency:

12.30 (1) is unable to retain Medicare certification and enrollment solely due to a lack of billing
12.31 to the Medicare program;

12.32 (2) meets all other applicable Medicare certification requirements based on an on-site
12.33 review completed by the commissioner of health; and

13.1 (3) serves primarily a pediatric population.

13.2 Subd. 4. **Commissioner's authority to terminate provider enrollment for lack of**
13.3 **submitted claims.** The commissioner may terminate the enrollment of an individual or
13.4 entity provider if the individual or entity provider has not submitted any claims in the
13.5 previous 12 consecutive calendar months.

13.6 Sec. 8. **[256B.0443] PROVIDER PAYMENT WITHHOLDS.**

13.7 (a) If the commissioner or the Centers for Medicare and Medicaid Services designates
13.8 a provider type as high-risk under section 256B.044, subdivision 1, the commissioner may
13.9 withhold payment from providers within that category upon initial enrollment for a 90-day
13.10 period.

13.11 (b) The withholding for each provider must begin on the date of the first submission of
13.12 a claim.

13.13 Sec. 9. **[256B.0444] ADDITIONAL PROVIDER ENROLLMENT REQUIREMENTS**
13.14 **FOR SPECIFIC PROVIDER TYPES.**

13.15 Subdivision 1. **Durable medical equipment provider or supplier.** (a) For purposes of
13.16 this subdivision, "durable medical equipment provider or supplier" means a medical supplier
13.17 that can purchase medical equipment or supplies for sale or rent to the general public and
13.18 is able to perform or arrange for necessary repairs to and maintenance of equipment offered
13.19 for sale or rent.

13.20 (b) Upon initial enrollment, reenrollment, and notification of revalidation, all durable
13.21 medical equipment, prosthetics, orthotics, and supplies medical suppliers meeting the durable
13.22 medical equipment provider or supplier definition in paragraph (a), operating in Minnesota,
13.23 and receiving Medicaid money must purchase a surety bond that is annually renewed,
13.24 designates the Department of Human Services as the obligee, and is submitted in a form
13.25 approved by the commissioner. For purposes of this paragraph, the following medical
13.26 suppliers are not required to obtain a surety bond: a federally qualified health center, a home
13.27 health agency, the Indian Health Service, a pharmacy, and a rural health clinic.

13.28 (c) At the time of initial enrollment or reenrollment, durable medical equipment providers
13.29 or suppliers defined in paragraph (a) must purchase a surety bond of $50,000. If a revalidating
13.30 provider's Medicaid revenue in the previous calendar year is up to and including $300,000,
13.31 the provider agency must purchase a surety bond of $50,000. If a revalidating provider's
13.32 Medicaid revenue in the previous calendar year is over $300,000, the provider agency must

14.1 purchase a surety bond of $100,000. The surety bond must allow for recovery of costs and
14.2 fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions
14.3 from a surety bond must occur within six years from the date the debt is affirmed by a final
14.4 agency decision. An agency decision is final when the right to appeal the debt has been
14.5 exhausted or the time to appeal has expired under section 256B.064.

14.6 Subd. 2. **Providers licensed by the commissioner of human services.** An enrolled
14.7 provider that is also licensed by the commissioner under chapter 245A must designate an
14.8 individual as the licensee's compliance officer under section 256B.044, subdivision 7,
14.9 paragraph (b).

14.10 Subd. 3. **Providers licensed by the commissioner of health.** An enrolled provider that
14.11 is also licensed by the commissioner of health as a home care provider under chapter 144A
14.12 with a home and community-based services designation under section 144A.484 on the
14.13 home care license, or as an assisted living facility under chapter 144G, must designate an
14.14 individual as the licensee's compliance officer under section 256B.044, subdivision 7,
14.15 paragraph (b).

14.16 Sec. 10. Minnesota Statutes 2024, section 256B.057, subdivision 9, is amended to read:

14.17 Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid for
14.18 a person who is employed and who:

14.19 (1) but for excess earnings or assets meets the definition of disabled under the
14.20 Supplemental Security Income program; and

14.21 (2) pays a premium and other obligations under paragraph (d).

14.22 (b) For purposes of eligibility, there is a $65 earned income disregard. To be eligible
14.23 for medical assistance under this subdivision, a person must have more than $65 of earned
14.24 income, be receiving an unemployment insurance benefit under chapter 268 that the person
14.25 began receiving while eligible under this subdivision, or be receiving family and medical
14.26 leave benefits under chapter 268B that the person began receiving while eligible under this
14.27 subdivision. A person who is self-employed must file and pay all applicable taxes. Any
14.28 spousal income shall be disregarded for purposes of eligibility and premium determinations.

14.29 (c) After the month of enrollment, a person enrolled in medical assistance under this
14.30 subdivision who would otherwise be ineligible and be disenrolled due to one of the following
14.31 circumstances may retain eligibility for up to four consecutive months after a month of job
14.32 loss if the person:

15.1 (1) is temporarily unable to work and without receipt of earned income due to a medical
15.2 condition, as verified by a physician, advanced practice registered nurse, or physician
15.3 assistant; or

15.4 (2) loses employment for reasons not attributable to the enrollee, and is without receipt
15.5 of earned income.

15.6 To receive a four-month extension of continued eligibility under this paragraph, enrollees
15.7 must verify the medical condition or provide notification of job loss, continue to meet all
15.8 other eligibility requirements, and continue to pay all calculated premium costs.

15.9 (d) All enrollees must pay a premium to be eligible for medical assistance under this
15.10 subdivision, except as provided under clause (5).

15.11 (1) An enrollee must pay the greater of a $35 premium or the premium calculated based
15.12 on the person's gross earned and unearned income and the applicable family size using a
15.13 sliding fee scale established by the commissioner, which begins at one percent of income
15.14 at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for
15.15 those with incomes at or above 300 percent of the federal poverty guidelines.

15.16 (2) Annual adjustments in the premium schedule based upon changes in the federal
15.17 poverty guidelines shall be effective for premiums due in July of each year.

15.18 (3) All enrollees who receive unearned income must pay one-half of one percent of
15.19 unearned income in addition to the premium amount, except as provided under clause (5).

15.20 (4) Increases in benefits under title II of the Social Security Act shall not be counted as
15.21 income for purposes of this subdivision until July 1 of each year.

15.22 (5) Effective July 1, 2009, American Indians are exempt from paying premiums as
15.23 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public
15.24 Law 111-5. For purposes of this clause, an American Indian is any person who meets the
15.25 definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

15.26 (e) A person's eligibility and premium shall be determined by the local county agency.
15.27 Premiums must be paid to the commissioner. All premiums are dedicated to the
15.28 commissioner.

15.29 (f) Any required premium shall be determined at application and redetermined at the
15.30 enrollee's 12-month income review or when a change in income or household size is reported.
15.31 Enrollees must report any change in income or household size within 30 days of when the
15.32 change occurs. A decreased premium resulting from a reported change in income or
15.33 household size shall be effective the first day of the next available billing month after the

16.1 change is reported. Except for changes occurring from annual cost-of-living increases, a
16.2 change resulting in an increased premium shall not affect the premium amount until the
16.3 next 12-month review.

16.4 (g) Premium payment is due upon notification from the commissioner of the premium
16.5 amount required. Premiums may be paid in installments at the discretion of the commissioner.

16.6 (h) Nonpayment of the premium shall result in denial or termination of medical assistance
16.7 unless the person demonstrates good cause for nonpayment. "Good cause" means an excuse
16.8 for the enrollee's failure to pay the required premium when due because the circumstances
16.9 were beyond the enrollee's control or not reasonably foreseeable. The commissioner shall
16.10 determine whether good cause exists based on the weight of the supporting evidence
16.11 submitted by the enrollee to demonstrate good cause. The commissioner must not determine
16.12 that good cause exists for a month for which the premium has already been paid. Except
16.13 when an installment agreement is accepted by the commissioner, all persons disenrolled
16.14 for nonpayment of a premium must pay any past due premiums as well as current premiums
16.15 due prior to being reenrolled. Nonpayment shall include payment with a returned, refused,
16.16 or dishonored instrument. The commissioner may require a guaranteed form of payment as
16.17 the only means to replace a returned, refused, or dishonored instrument.

16.18 (i) For enrollees whose income does not exceed 200 percent of the federal poverty
16.19 guidelines and who are also enrolled in Medicare, the commissioner shall reimburse the
16.20 enrollee for Medicare part B premiums under section 256B.0625, subdivision 15, paragraph
16.21 (a).

16.22 (j) The commissioner is authorized to determine that a premium amount was calculated
16.23 or billed in error, make corrections to financial records and billing systems, and refund
16.24 premiums collected in error.

16.25 Sec. 11. Minnesota Statutes 2024, section 256B.0625, subdivision 4, is amended to read:

16.26 Subd. 4. **Outpatient and physician-directed clinic services.** Medical assistance covers
16.27 outpatient hospital or physician-directed clinic services. ~~The~~ All services provided by
16.28 physician-directed clinic staff ~~shall include at least two physicians and all services shall~~
16.29 must be ~~provided~~ under the ~~direct supervision~~ direction of a physician. Hospital outpatient
16.30 departments are subject to the same limitations and reimbursements as other enrolled vendors
16.31 for all services, except initial triage, emergency services, and services not provided or
16.32 immediately available in clinics, physicians' offices, or by other enrolled providers.
16.33 "Emergency services" means those medical services required for the immediate diagnosis
16.34 and treatment of medical conditions that, if not immediately diagnosed and treated, could

17.1 lead to serious physical or mental disability or death or are necessary to alleviate severe
17.2 pain. Neither the hospital, its employees, nor any physician or dentist, shall be liable in any
17.3 action arising out of a determination not to render emergency services or care if reasonable
17.4 care is exercised in determining the condition of the person, or in determining the
17.5 appropriateness of the facilities, or the qualifications and availability of personnel to render
17.6 these services consistent with this section.

17.7 **EFFECTIVE DATE.** This section is effective upon federal approval.

17.8 Sec. 12. Minnesota Statutes 2025 Supplement, section 256B.0759, subdivision 4, is
17.9 amended to read:

17.10 Subd. 4. **Provider payment rates.** (a) Payment rates for participating providers must
17.11 be increased for services provided to medical assistance enrollees. To receive a rate increase,
17.12 participating providers must meet demonstration project requirements and provide evidence
17.13 of formal referral arrangements with providers delivering step-up or step-down levels of
17.14 care. Providers that have enrolled in the demonstration project but have not met the provider
17.15 standards under subdivision 3 as of July 1, 2022, are not eligible for a rate increase under
17.16 this subdivision until the date that the provider meets the provider standards in subdivision
17.17 3. Services provided from July 1, 2022, to the date that the provider meets the provider
17.18 standards under subdivision 3 shall be reimbursed at rates according to section 254B.0505,
17.19 subdivision 1. Rate increases paid under this subdivision to a provider for services provided
17.20 between July 1, 2021, and July 1, 2022, are not subject to recoupment when the provider
17.21 is taking meaningful steps to meet demonstration project requirements that are not otherwise
17.22 required by law, and the provider provides documentation to the commissioner, upon request,
17.23 of the steps being taken.

17.24 (b) The commissioner may temporarily suspend payments to the provider according to
17.25 section ~~256B.04, subdivision 21, paragraph (d)~~ 256B.0442, subdivision 1, if the provider
17.26 does not meet the requirements in paragraph (a). Payments withheld from the provider must
17.27 be made once the commissioner determines that the requirements in paragraph (a) are met.

17.28 (c) For outpatient individual and group substance use disorder services under section
17.29 254B.0505, subdivision 1, clause (1), and adolescent treatment programs that are licensed
17.30 as outpatient treatment programs according to sections 245G.01 to 245G.18, provided on
17.31 or after January 1, 2021, payment rates must be increased by 20 percent over the rates in
17.32 effect on December 31, 2020.

17.33 (d) Effective January 1, 2021, and contingent on annual federal approval, managed care
17.34 plans and county-based purchasing plans must reimburse providers of the substance use

disorder services meeting the criteria described in paragraph (a) who are employed by or under contract with the plan an amount that is at least equal to the fee-for-service base rate payment for the substance use disorder services described in paragraph (c). The commissioner must monitor the effect of this requirement on the rate of access to substance use disorder services and residential substance use disorder rates. Capitation rates paid to managed care organizations and county-based purchasing plans must reflect the impact of this requirement. This paragraph expires if federal approval is not received at any time as required under this paragraph.

(e) Effective July 1, 2021, contracts between managed care plans and county-based purchasing plans and providers to whom paragraph (d) applies must allow recovery of payments from those providers if, for any contract year, federal approval for the provisions of paragraph (d) is not received, and capitation rates are adjusted as a result. Payment recoveries must not exceed the amount equal to any decrease in rates that results from this provision.

(f) For substance use disorder services with medications for opioid use disorder under section 254B.0505, subdivision 1, clause (7), provided on or after January 1, 2021, payment rates must be increased by 20 percent over the rates in effect on December 31, 2020. Upon implementation of new rates according to section 254B.121, the 20 percent increase will no longer apply.

Sec. 13. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 16, is amended to read:

Subd. 16. **Agency duties.** (a) An agency delivering an EIDBI service under this section must:

(1) enroll as a medical assistance Minnesota health care program provider according to Minnesota Rules, part 9505.0195, and ~~section 256B.04, subdivision 21~~ sections 256B.044 to 256B.0444, and meet all applicable provider standards and requirements;

(2) designate an individual as the agency's compliance officer who must perform the duties described in section ~~256B.04, subdivision 21, paragraph (g)~~ 256B.044, subdivision 7, paragraph (b);

(3) demonstrate compliance with federal and state laws for the delivery of and billing for EIDBI service;

(4) verify and maintain records of a service provided to the person or the person's legal representative as required under Minnesota Rules, parts 9505.2175 and 9505.2197;

19.1 (5) demonstrate that while enrolled or seeking enrollment as a Minnesota health care
19.2 program provider the agency did not have a lead agency contract or provider agreement
19.3 discontinued because of a conviction of fraud; or did not have an owner, board member, or
19.4 manager fail a state or federal criminal background check or appear on the list of excluded
19.5 individuals or entities maintained by the federal Department of Human Services Office of
19.6 Inspector General;

19.7 (6) have established business practices including written policies and procedures, internal
19.8 controls, and a system that demonstrates the organization's ability to deliver quality EIDBI
19.9 services, appropriately submit claims, conduct required staff training, document staff
19.10 qualifications, document service activities, and document service quality;

19.11 (7) have an office located in Minnesota or a border state;

19.12 (8) initiate a background study as required under subdivision 16a;

19.13 (9) report maltreatment according to section 626.557 and chapter 260E;

19.14 (10) comply with any data requests consistent with the Minnesota Government Data
19.15 Practices Act, sections 256B.064 and 256B.27;

19.16 (11) provide training for all agency staff on the requirements and responsibilities listed
19.17 in the Maltreatment of Minors Act, chapter 260E, and the Vulnerable Adult Protection Act,
19.18 section 626.557, including mandated and voluntary reporting, nonretaliation, and the agency's
19.19 policy for all staff on how to report suspected abuse and neglect;

19.20 (12) have a written policy to resolve issues collaboratively with the person and the
19.21 person's legal representative when possible. The policy must include a timeline for when
19.22 the person and the person's legal representative will be notified about issues that arise in
19.23 the provision of services;

19.24 (13) provide the person's legal representative with prompt notification if the person is
19.25 injured while being served by the agency. An incident report must be completed by the
19.26 agency staff member in charge of the person. A copy of all incident and injury reports must
19.27 remain on file at the agency for at least five years from the report of the incident;

19.28 (14) before starting a service, provide the person or the person's legal representative a
19.29 description of the treatment modality that the person shall receive, including the staffing
19.30 certification levels and training of the staff who shall provide a treatment;

19.31 (15) provide clinical supervision for a minimum of one hour for every 16 hours of direct
19.32 treatment per person, unless otherwise authorized in the person's individual treatment plan;
19.33 and

20.1 (16) provide required EIDBI intervention observation and direction at least once per
20.2 month. Notwithstanding subdivision 13, paragraph (l), required EIDBI intervention
20.3 observation and direction under this clause may be conducted via telehealth provided that
20.4 no more than two consecutive monthly required EIDBI intervention observation and direction
20.5 sessions under this clause are conducted via telehealth.

20.6 (b) Upon request of the commissioner, an agency delivering services under this section
20.7 must:

20.8 (1) identify the agency's controlling individuals, as defined under section 245A.02,
20.9 subdivision 5a;

20.10 (2) provide disclosures of the use of billing agencies and other consultants who do not
20.11 provide EIDBI services; and

20.12 (3) provide copies of any contracts with consultants or independent contractors who do
20.13 not provide EIDBI services, including hours contracted and responsibilities.

20.14 (c) When delivering the ITP, and annually thereafter, an agency must provide the person
20.15 or the person's legal representative with:

20.16 (1) a written copy and a verbal explanation of the person's or person's legal
20.17 representative's rights and the agency's responsibilities;

20.18 (2) documentation in the person's file the date that the person or the person's legal
20.19 representative received a copy and explanation of the person's or person's legal
20.20 representative's rights and the agency's responsibilities; and

20.21 (3) reasonable accommodations to provide the information in another format or language
20.22 as needed to facilitate understanding of the person's or person's legal representative's rights
20.23 and the agency's responsibilities.

20.24 Sec. 14. Minnesota Statutes 2024, section 256B.0949, subdivision 17, is amended to read:

20.25 Subd. 17. **Provider shortage; authority for exceptions.** (a) In consultation with the
20.26 Early Intensive Developmental and Behavioral Intervention Advisory Council and
20.27 stakeholders, including agencies, professionals, parents of people with ASD or a related
20.28 condition, and advocacy organizations, the commissioner shall determine if a shortage of
20.29 EIDBI providers exists. For the purposes of this subdivision, "shortage of EIDBI providers"
20.30 means a lack of availability of providers who meet the EIDBI provider qualification
20.31 requirements under subdivision 15 that results in the delay of access to timely services under
20.32 this section, or that significantly impairs the ability of a provider agency to have sufficient

21.1 providers to meet the requirements of this section. The commissioner shall consider
21.2 geographic factors when determining the prevalence of a shortage. The commissioner may
21.3 determine that a shortage exists only in a specific region of the state, multiple regions of
21.4 the state, or statewide. The commissioner shall also consider the availability of various types
21.5 of treatment modalities covered under this section.

21.6 (b) The commissioner, in consultation with the Early Intensive Developmental and
21.7 Behavioral Intervention Advisory Council and stakeholders, must establish processes and
21.8 criteria for granting an exception under this paragraph. The commissioner may grant an
21.9 exception only if the exception would not compromise a person's safety and not diminish
21.10 the effectiveness of the treatment. The commissioner may establish an expiration date for
21.11 an exception granted under this paragraph. The commissioner may grant an exception for
21.12 the following:

21.13 (1) EIDBI provider qualifications under this section;

21.14 (2) medical assistance provider enrollment requirements under ~~section 256B.04,~~
21.15 ~~subdivision 21~~ <u>sections 256B.044 to 256B.0444</u>; or

21.16 (3) EIDBI provider or agency standards or requirements.

21.17 (c) If the commissioner, in consultation with the Early Intensive Developmental and
21.18 Behavioral Intervention Advisory Council and stakeholders, determines that a shortage no
21.19 longer exists, the commissioner must submit a notice that a shortage no longer exists to the
21.20 chairs and ranking minority members of the senate and the house of representatives
21.21 committees with jurisdiction over health and human services. The commissioner must post
21.22 the notice for public comment for 30 days. The commissioner shall consider public comments
21.23 before submitting to the legislature a request to end the shortage declaration. The
21.24 commissioner shall not declare the shortage of EIDBI providers ended without direction
21.25 from the legislature to declare it ended.

21.26 Sec. 15. Minnesota Statutes 2025 Supplement, section 256B.695, subdivision 5, is amended
21.27 to read:

21.28 Subd. 5. **CARMA enrollment.** (a) Subject to ~~paragraphs~~ <u>paragraph</u> (d) ~~and (e)~~, eligible
21.29 individuals must be automatically enrolled in CARMA, but may decline enrollment. Eligible
21.30 individuals may enroll in fee-for-service medical assistance. Eligible individuals may change
21.31 their CARMA elections on an annual basis.

(b) Eligible individuals must be able to enroll in CARMA through the selection process in accordance with the election period established in section 256B.69, subdivision 4, paragraph (e).

(c) Enrollees who were not previously enrolled in the medical assistance program or MinnesotaCare can change their selection once within the first year after enrollment in CARMA. Enrollees who were not previously enrolled in CARMA have 90 days to make a change and changes are allowed for additional special circumstances.

(d) The commissioner may not offer a second health plan to eligible individuals other than, ~~and~~ or in addition to, CARMA except that the commissioner may offer a second health plan to eligible individuals ~~when another health plan is~~ enrolling in MinnesotaCare, if required by federal law or rule. Eligible individuals who do not select a health plan at the time of enrollment must automatically be enrolled in CARMA.

(e) The commissioner may offer a replacement plan to eligible individuals, as determined by the commissioner, when counties administering CARMA have their contract terminated for cause.

~~(e)~~ (f) The commissioner may, on a county-by-county basis, offer a health plan other than~~, and in addition to,~~ CARMA to individuals who are eligible for both Medicare and medical assistance due to age, income, or disability if ~~the commissioner deems it necessary for enrollees to have another choice of health plan. Factors the commissioner must consider when determining if the other health plan is necessary include the number of available Medicare Advantage Plan options that are not special needs plans in the county, the size of the enrolling population, the additional administrative burden placed on providers and counties by multiple health plan options in a county, the need to ensure the viability and success of the CARMA program, and the impact to the medical assistance program~~ there is not already a health plan available under CARMA.

~~(f) In counties where the commissioner is required by federal law or elects to offer a second health plan other than CARMA pursuant to paragraphs (d) and (e), eligible enrollees who do not select a health plan at the time of enrollment must automatically be enrolled in CARMA.~~

(g) This subdivision supersedes section 256B.694.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 16. Minnesota Statutes 2024, section 256L.05, subdivision 3, is amended to read:

Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the first day of the month following the month in which eligibility is approved and the first premium payment has been received. The effective date of coverage for new members added to the family is the first day of the month following the month in which the change is reported. All eligibility criteria must be met by the family at the time the new family member is added. The income of the new family member is included with the family's modified adjusted gross income and the adjusted premium begins in the month the new family member is added.

(b) The initial premium must be received by the last working day of the month for coverage to begin the first day of the following month.

(c) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which an eligible person may have coverage and the commissioner shall use cost avoidance techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

(d) The effective date of coverage for individuals or families who are exempt from paying premiums under section 256L.15, ~~subdivision~~ subdivisions 1~~, paragraph (c)~~ and 2, is the first day of the month following the month in which eligibility is approved.

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

Sec. 17. Minnesota Statutes 2024, section 256L.06, subdivision 3, is amended to read:

Subd. 3. **Commissioner's duties and payment.** (a) Premiums are dedicated to the commissioner for MinnesotaCare.

(b) The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon both increases and decreases in enrollee income, at the time the change in income is reported; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. Failure to pay includes payment with a dishonored check, a returned automatic bank withdrawal, or a refused credit card or debit card payment. The commissioner may demand a guaranteed form of payment, including a cashier's check or a money order, as the only means to replace a dishonored, returned, or refused payment.

(c) Premiums are calculated on a calendar month basis and may be paid on a monthly, quarterly, or semiannual basis, with the first payment due upon notice from the commissioner

24.1 of the premium amount required. The commissioner shall inform applicants and enrollees
24.2 of these premium payment options. Premium payment is required before enrollment is
24.3 complete and to maintain ~~eligibility~~ coverage in MinnesotaCare. Premium payments received
24.4 before noon are credited the same day. Premium payments received after noon are credited
24.5 on the next working day.

24.6 (d) Nonpayment of the premium will result in disenrollment from the plan effective for
24.7 the calendar month following the month for which the premium was due. Persons disenrolled
24.8 for nonpayment may not reenroll prior to the first day of the month following the payment
24.9 of an amount equal to ~~two months' premiums~~ one monthly premium.

24.10 (e) The commissioner shall forgive the past-due premium for persons disenrolled under
24.11 paragraph (d) prior to issuing a premium invoice for the ~~fourth~~ next month ~~following~~
24.12 ~~disenrollment~~.

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

24.14 Sec. 18. Laws 2024, chapter 125, article 4, section 12, subdivision 5, is amended to read:

24.15 Subd. 5. **Report.** By ~~December 15, 2025~~ November 30, 2026, the commissioner must
24.16 provide a summary report on the pilot program to the chairs and ranking minority members
24.17 of the legislative committees with jurisdiction over mental health and county correctional
24.18 facilities.

24.19 **EFFECTIVE DATE.** This section is effective retroactively from December 15, 2025.