

SENATE  
STATE OF MINNESOTA  
NINETY-FOURTH SESSION

S.F. No. 3755

(SENATE AUTHORS: HOFFMAN, Fateh and Utke)

DATE	D-PG	OFFICIAL STATUS
02/23/2026	6363	Introduction and first reading Referred to Health and Human Services
03/02/2026	6464	Withdrawn and re-referred to Human Services
03/05/2026	6502a	Comm report: To pass as amended and re-refer to Health and Human Services
03/18/2026	6807a	Comm report: To pass as amended and re-refer to Human Services HF substituted in committee HF3379

1.1 A bill for an act

1.2 relating to human services; repealing housing stabilization services; clarifying the

1.3 commissioner's authority to terminate or modify the medical assistance program;

1.4 providing a onetime rate add-on for prepayment review delays; requiring a report;

1.5 amending Minnesota Statutes 2024, sections 256B.04, subdivision 24, by adding

1.6 a subdivision; 256B.0658; 256L.03, subdivision 1; Minnesota Statutes 2025

1.7 Supplement, sections 245C.03, subdivision 6; 245C.04, subdivision 6; 245C.10,

1.8 subdivision 6; 256B.04, subdivision 21; 256B.0701, subdivision 9; repealing

1.9 Minnesota Statutes 2024, section 256B.051, subdivisions 1, 4, 7; Minnesota Statutes

1.10 2025 Supplement, section 256B.051, subdivisions 2, 3, 5, 6, 6a, 6b, 8, 9, 10; Laws

1.11 2025, First Special Session chapter 3, article 18, section 3.

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

1.13 Section 1. Minnesota Statutes 2025 Supplement, section 245C.03, subdivision 6, is amended

1.14 to read:

1.15 Subd. 6. **Unlicensed home and community-based waiver providers of service to**

1.16 **seniors and individuals with disabilities and providers of housing stabilization**

1.17 **services.** (a) For providers of services specified in the federally approved home and

1.18 community-based waiver plans under section 256B.4912 and providers of housing

1.19 stabilization services under section 256B.051, the commissioner shall conduct background

1.20 studies on any individual who is an owner with at least a five percent ownership stake in

1.21 the provider, an operator of the provider, or an employee or volunteer for the provider who

1.22 has direct contact with people receiving the services. The individual studied must meet the

1.23 requirements of this chapter prior to providing waiver services and as part of ongoing

1.24 enrollment.

1.25 (b) The requirements in paragraph (a) apply to consumer-directed community supports

1.26 under section 256B.4911.

2.1 (c) For purposes of this section, "operator" includes but is not limited to a managerial  
2.2 officer who oversees the billing, management, or policies of the services provided.

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

2.4 Sec. 2. Minnesota Statutes 2025 Supplement, section 245C.04, subdivision 6, is amended  
2.5 to read:

2.6 Subd. 6. **Unlicensed home and community-based waiver providers of service to**  
2.7 **seniors and individuals with disabilities and ~~providers of housing stabilization~~**  
2.8 **services.** (a) Providers required to initiate background studies under section 245C.03,  
2.9 subdivision 6, must initiate a study using the electronic system known as NETStudy 2.0  
2.10 before the individual begins in a position allowing direct contact with persons served by  
2.11 the provider. New providers must initiate a study under this subdivision before initial  
2.12 enrollment if the provider has not already initiated background studies as part of the service  
2.13 licensure requirements.

2.14 (b) Except as provided in paragraph (c), the providers must initiate a background study  
2.15 annually of an individual required to be studied under section 245C.03, subdivision 6.

2.16 (c) After an initial background study under this subdivision is initiated on an individual  
2.17 by a provider of both services licensed by the commissioner and the unlicensed services  
2.18 under this subdivision, a repeat annual background study is not required if:

2.19 (1) the provider maintains compliance with the requirements of section 245C.07,  
2.20 paragraph (a), regarding one individual with one address and telephone number as the person  
2.21 to receive sensitive background study information for the multiple programs that depend  
2.22 on the same background study, and that the individual who is designated to receive the  
2.23 sensitive background information is capable of determining, upon the request of the  
2.24 commissioner, whether a background study subject is providing direct contact services in  
2.25 one or more of the provider's programs or services and, if so, at which location or locations;  
2.26 and

2.27 (2) the individual who is the subject of the background study provides direct contact  
2.28 services under the provider's licensed program for at least 40 hours per year so the individual  
2.29 will be recognized by a probation officer or corrections agent to prompt a report to the  
2.30 commissioner regarding criminal convictions as required under section 245C.05, subdivision  
2.31 7.

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

3.1 Sec. 3. Minnesota Statutes 2025 Supplement, section 245C.10, subdivision 6, is amended  
3.2 to read:

3.3 Subd. 6. **Unlicensed home and community-based waiver providers of service to**  
3.4 **seniors and individuals with disabilities and ~~providers of housing stabilization~~**  
3.5 **services.** The commissioner shall recover the cost of background studies initiated by  
3.6 unlicensed home and community-based waiver providers of service to seniors and individuals  
3.7 with disabilities under section 256B.4912 ~~and providers of housing stabilization services~~  
3.8 ~~under section 256B.051~~ through a fee of no more than \$44 per study.

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

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

3.12 Subd. 21. **Provider enrollment.** (a) The commissioner shall enroll providers and conduct  
3.13 screening activities as required by Code of Federal Regulations, title 42, section 455, subpart  
3.14 E. A provider must enroll each provider-controlled location where direct services are  
3.15 provided. The commissioner may deny a provider's incomplete application if a provider  
3.16 fails to respond to the commissioner's request for additional information within 60 days of  
3.17 the request. The commissioner must conduct a background study under chapter 245C,  
3.18 including a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses  
3.19 (1) to (5), for a provider described in this paragraph. The background study requirement  
3.20 may be satisfied if the commissioner conducted a fingerprint-based background study on  
3.21 the provider that includes a review of databases in section 245C.08, subdivision 1, paragraph  
3.22 (a), clauses (1) to (5).

3.23 (b) The commissioner shall revalidate:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.25 (3) serves primarily a pediatric population.

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

6.1 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14.  
6.2 The commissioner's designations are not subject to administrative appeal.

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

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

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

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

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

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

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

7.11 Sec. 5. Minnesota Statutes 2024, section 256B.04, subdivision 24, is amended to read:

7.12 Subd. 24. **Medicaid waiver requests and state plan amendments; notice; public**  
 7.13 **comments.** (a) The commissioner shall notify the chairs and ranking minority members of  
 7.14 the legislative committees with jurisdiction over medical assistance at least 30 days before  
 7.15 submitting a new Medicaid waiver request to the federal government.

7.16 (b) Prior to submitting any Medicaid waiver request or Medicaid state plan amendment  
 7.17 to the federal government for approval, the commissioner shall publish the text of the waiver  
 7.18 request or state plan amendment, and a summary of and explanation of the need for the  
 7.19 request, on the agency's website and provide a 30-day public comment period. The  
 7.20 commissioner shall notify the public of the availability of this information through the  
 7.21 agency's electronic subscription service. The commissioner shall publish the text of all  
 7.22 public comments on the agency's website and consider public comments when preparing  
 7.23 the final waiver request or state plan amendment that is to be submitted to the federal  
 7.24 government for approval.

7.25 (c) The commissioner shall also publish on the agency's website notice of any federal  
 7.26 decision related to the state request for approval, within 30 days of the decision. This notice  
 7.27 must describe any modifications to the state request that have been agreed to by the  
 7.28 commissioner as a condition of receiving federal approval.

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

8.1 Sec. 6. Minnesota Statutes 2024, section 256B.04, is amended by adding a subdivision to  
8.2 read:

8.3 Subd. 24a. **Medicaid waiver requests and state plan amendments; prohibited**  
8.4 **actions.** The commissioner must not take the following actions without prior enactment of  
8.5 legislative authorization:

8.6 (1) terminate a medical assistance program, waiver, or benefit;

8.7 (2) request federal assistance with terminating a medical assistance program, waiver, or  
8.8 benefit; or

8.9 (3) substantially redesign a medical assistance program, waiver, or benefit.

8.10 Sec. 7. Minnesota Statutes 2024, section 256B.0658, is amended to read:

8.11 **256B.0658 HOUSING ACCESS GRANTS.**

8.12 Subdivision 1. **Establishment.** The commissioner of human services shall award through  
8.13 a competitive process contracts for grants to public and private agencies to support and  
8.14 assist individuals with a disability ~~as defined in section 256B.051, subdivision 2, paragraph~~  
8.15 ~~(e)~~, to access housing.

8.16 Subd. 2. **Definition.** (a) For the purposes of this section, the term defined in this  
8.17 subdivision has the meaning given.

8.18 (b) "Individual with a disability" means:

8.19 (1) an individual who is aged, blind, or disabled as determined by the criteria under  
8.20 sections 216(i)(1) and 221 of the Social Security Act; or

8.21 (2) an individual who meets a category of eligibility under section 256D.05, subdivision  
8.22 1, paragraph (a), clause (1), (4), (5) to (8), or (13).

8.23 Subd. 3. **Allowable uses of grant funds.** Grants may be awarded to agencies that may  
8.24 include, but are not limited to, the following supports: assessment to ensure suitability of  
8.25 housing, accompanying an individual to look at housing, filling out applications and rental  
8.26 agreements, meeting with landlords, helping with Section 8 or other program applications,  
8.27 helping to develop a budget, obtaining furniture and household goods, if necessary, and  
8.28 assisting with any problems that may arise with housing.

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

9.1 Sec. 8. Minnesota Statutes 2025 Supplement, section 256B.0701, subdivision 9, is amended  
9.2 to read:

9.3 Subd. 9. **Provider qualifications and duties.** A provider is eligible for reimbursement  
9.4 under this section only if the provider:

9.5 (1) is confirmed by the commissioner as an eligible provider after a pre-enrollment risk  
9.6 assessment under subdivision 10;

9.7 (2) is enrolled as a medical assistance Minnesota health care program provider and meets  
9.8 all applicable provider standards and requirements;

9.9 ~~(3) demonstrates compliance with federal and state laws and policies for housing~~  
9.10 ~~stabilization services as determined by the commissioner;~~

9.11 (3) demonstrates compliance with federal and state laws and policies for recuperative  
9.12 care services as determined by the commissioner;

9.13 (4) complies with background study requirements under chapter 245C and maintains  
9.14 documentation of background study requests and results;

9.15 (5) provides at the time of enrollment, reenrollment, and revalidation in a format  
9.16 determined by the commissioner, proof of surety bond coverage for each business location  
9.17 providing services. Upon new enrollment, or if the provider's medical assistance revenue  
9.18 in the previous calendar year is \$300,000 or less, the provider agency must purchase a surety  
9.19 bond of \$50,000. If the provider's medical assistance revenue in the previous year is over  
9.20 \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety bond  
9.21 must be in a form approved by the commissioner, must be renewed annually, and must  
9.22 allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain  
9.23 monetary recovery or sanctions from a surety bond must occur within six years from the  
9.24 date the debt is affirmed by a final agency decision. An agency decision is final when the  
9.25 right to appeal the debt has been exhausted or the time to appeal has expired under section  
9.26 256B.064;

9.27 (6) ensures all controlling individuals and employees of the agency complete annual  
9.28 vulnerable adult training;

9.29 (7) completes compliance training as required under subdivision 11; and

9.30 (8) complies with the habitability inspection requirements in subdivision 13.

10.1 Sec. 9. Minnesota Statutes 2024, section 256L.03, subdivision 1, is amended to read:

10.2 Subdivision 1. **Covered health services.** (a) "Covered health services" means the health  
 10.3 services reimbursed under chapter 256B, with the exception of special education services,  
 10.4 home care nursing services, nonemergency medical transportation services, personal care  
 10.5 assistance and case management services, community first services and supports under  
 10.6 section 256B.85, behavioral health home services under section 256B.0757, ~~housing~~  
 10.7 ~~stabilization services under section 256B.051~~, and nursing home or intermediate care facilities  
 10.8 services.

10.9 (b) Covered health services shall be expanded as provided in this section.

10.10 (c) For the purposes of covered health services under this section, "child" means an  
 10.11 individual younger than 19 years of age.

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

10.13 Sec. 10. **HOUSING STABILIZATION SERVICES REDESIGN.**

10.14 **Subdivision 1. Direction to the commissioner.** The commissioner of human services  
 10.15 must develop recommendations for establishing a program to support individuals  
 10.16 experiencing or at risk of homelessness to obtain and maintain safe and stable housing.

10.17 **Subd. 2. Recommendations.** In developing recommendations, the commissioner must:

10.18 (1) prioritize establishing a housing services benefit specifically for Minnesota Tribal  
 10.19 governments and urban Indian organizations;

10.20 (2) utilize evidence-based and promising practices to prevent and reduce homelessness;

10.21 (3) identify gaps in available housing services and supports and not duplicate any existing  
 10.22 programs;

10.23 (4) identify expected outcomes and measures to track effectiveness of the proposed  
 10.24 program;

10.25 (5) incorporate tools and system changes to protect program integrity and prevent fraud,  
 10.26 waste, and abuse; and

10.27 (6) include statutory changes and state appropriations to implement the proposed program.

10.28 **Subd. 3. Community engagement.** In developing recommendations, the commissioner  
 10.29 must consult with the legislature, other state agencies, Tribal Nations, and community  
 10.30 partners, including counties, providers, health plans, and people experiencing or at risk of  
 10.31 homelessness.

11.1 Subd. 4. **Legislative report.** By September 15, 2027, the commissioner must submit to  
11.2 the chairs and ranking minority members of the legislative committees with jurisdiction  
11.3 over health and human services policy and finance a report including final recommendations  
11.4 to establish both a housing services benefit specifically for Tribal governments and urban  
11.5 Indian organizations and a statewide housing services benefit.

11.6 **EFFECTIVE DATE.** This section is effective July 1, 2026.

11.7 Sec. 11. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**  
11.8 **ONETIME RATE ADD-ON FOR PREPAYMENT REVIEW DELAYS.**

11.9 The commissioner of human services must implement a onetime rate add-on for all  
11.10 fee-for-service providers impacted by the medical assistance payment delays that occurred  
11.11 in December 2025 and January 2026 as a result of the commissioner's implementation of  
11.12 prepayment review. Only providers who are not under active fraud investigations or payment  
11.13 withholds under Minnesota Statutes, section 256B.064, are eligible for a rate add-on under  
11.14 this section. The amount of the rate add-on is equal to the costs to the provider as determined  
11.15 by the commissioner of short-term borrowing for four weeks to maintain operations during  
11.16 the medical assistance fee-for-services payment delay, or ten percent of the value of the  
11.17 provider's actual delayed payments, whichever is greater. The commissioner must implement  
11.18 the rate add-on on June 30, 2026, or upon federal approval, whichever is later.

11.19 Sec. 12. **REPEALER.**

11.20 (a) Minnesota Statutes 2024, section 256B.051, subdivisions 1, 4, and 7, are repealed.

11.21 (b) Minnesota Statutes 2025 Supplement, section 256B.051, subdivisions 2, 3, 5, 6, 6a,  
11.22 6b, 8, 9, and 10, are repealed.

11.23 (c) Laws 2025, First Special Session chapter 3, article 18, section 3, is repealed.

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

**256B.051 HOUSING STABILIZATION SERVICES.**

Subdivision 1. **Purpose.** Housing stabilization services are established to provide housing stabilization services to an individual with a disability that limits the individual's ability to obtain or maintain stable housing. The services support an individual's transition to housing in the community and increase long-term stability in housing, to avoid future periods of being at risk of homelessness or institutionalization.

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

(b) "Agency" means the legal entity that is enrolled with Minnesota health care programs as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide housing stabilization services and that has the legal responsibility to ensure that its employees carry out the responsibilities defined in this section.

(c) "At-risk of homelessness" means (1) an individual that is faced with a set of circumstances likely to cause the individual to become homeless, or (2) an individual previously homeless, who will be discharged from a correctional, medical, mental health, or treatment center, who lacks sufficient resources to pay for housing and does not have a permanent place to live.

(d) "Commissioner" means the commissioner of human services.

(e) "Employee of an agency" or "employee" means any person who is employed by an agency temporarily, part time, or full time and who performs work for at least 80 hours in a year for that agency in Minnesota. Employee does not include an independent contractor.

(f) "Homeless" means an individual or family lacking a fixed, adequate nighttime residence.

(g) "Individual with a disability" means:

(1) an individual who is aged, blind, or disabled as determined by the criteria used by the title 11 program of the Social Security Act, United States Code, title 42, section 416, paragraph (i), item (1); or

(2) an individual who meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), clause (1), (4), (5) to (8), or (13).

(h) "Institution" means a setting as defined in section 256B.0621, subdivision 2, clause (3), and the Minnesota Security Hospital as defined in section 253.20.

Subd. 3. **Eligibility.** An individual with a disability is eligible for housing stabilization services if the individual:

(1) is 18 years of age or older;

(2) is enrolled in medical assistance;

(3) has income at or below 150 percent of the federal poverty level;

(4) has an assessment of functional need that determines a need for services due to limitations caused by the individual's disability;

(5) resides in or plans to transition to a community-based setting as defined in Code of Federal Regulations, title 42, section 441.301 (c); and

(6) has housing instability evidenced by:

(i) being homeless or at-risk of homelessness;

(ii) being in the process of transitioning from, or having transitioned in the past six months from, an institution or licensed or registered setting;

(iii) being eligible for waiver services under chapter 256S or section 256B.092 or 256B.49; or

(iv) having been identified by a long-term care consultation under section 256B.0911 as at risk of institutionalization.

Subd. 4. **Assessment requirements.** (a) An individual's assessment of functional need must be conducted by one of the following methods:

(1) an assessor according to the criteria established in section 256B.0911, subdivisions 17 to 21, 23, 24, and 29 to 31, using a format established by the commissioner;

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(2) documented need for services as verified by a professional statement of need as defined in section 256I.03, subdivision 12; or

(3) according to the continuum of care coordinated assessment system established in Code of Federal Regulations, title 24, section 578.3, using a format established by the commissioner.

(b) An individual must be reassessed within one year of initial assessment, and annually thereafter.

**Subd. 5. Housing stabilization services.** (a) Housing stabilization services include housing transition services, housing and tenancy sustaining services, housing consultation services, and housing transition costs.

(b) Housing transition services are defined as:

(1) tenant screening and housing assessment;

(2) assistance with the housing search and application process;

(3) identifying resources to cover onetime moving expenses;

(4) ensuring a new living arrangement is safe and ready for move-in;

(5) assisting in arranging for and supporting details of a move; and

(6) developing a housing support crisis plan.

(c) Housing and tenancy sustaining services include:

(1) prevention and early identification of behaviors that may jeopardize continued stable housing;

(2) education and training on roles, rights, and responsibilities of the tenant and the property manager;

(3) coaching to develop and maintain key relationships with property managers and neighbors;

(4) advocacy and referral to community resources to prevent eviction when housing is at risk;

(5) assistance with housing recertification process;

(6) coordination with the tenant to regularly review, update, and modify the housing support and crisis plan; and

(7) continuing training on being a good tenant, lease compliance, and household management.

(d) Housing consultation services assist an individual with developing a person-centered plan when the individual is not eligible to receive person-centered planning through any other service.

(e) Housing transition costs are available to persons transitioning from a provider-controlled setting to the person's own home and include:

(1) security deposits; and

(2) essential furnishings and supplies.

**Subd. 6. Agency qualifications and duties.** An agency is eligible for reimbursement under this section only if the agency:

(1) is confirmed by the commissioner as an eligible provider after a pre-enrollment risk assessment under subdivision 6a;

(2) is enrolled as a medical assistance Minnesota health care program provider and meets all applicable provider standards and requirements;

(3) demonstrates compliance with federal and state laws and policies for housing stabilization services as determined by the commissioner;

(4) complies with background study requirements under chapter 245C and maintains documentation of background study requests and results;

(5) provides at the time of enrollment, reenrollment, and revalidation in a format determined by the commissioner, proof of surety bond coverage for each business location providing services. Upon new enrollment, or if the provider's medical assistance revenue in the previous calendar year is \$300,000 or less, the provider agency must purchase a surety bond of \$50,000. If the provider's medical assistance revenue in the previous year is over \$300,000, the provider agency must purchase

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a surety bond of \$100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and 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;

(6) directly provides housing stabilization services using employees of the agency and not by using a subcontractor or reporting agent;

(7) ensures all controlling individuals and employees of the agency complete annual vulnerable adult training; and

(8) completes compliance training as required under subdivision 6b.

Subd. 6a. **Pre-enrollment risk assessment.** (a) Prior to enrolling a housing stabilization services agency, the commissioner must complete a pre-enrollment risk assessment of the agency seeking to enroll to confirm the agency's eligibility and the agency's ability to meet the requirements of this section. In completing this assessment, the commissioner must consider:

(1) the potential agency's history of performing services similar to those required by this section;

(2) whether the services require the potential agency to perform duties at a significantly increased scale and, if so, whether the potential agency has the capability and organizational capacity to do so;

(3) the potential agency's financial information and internal controls; and

(4) the potential agency's compliance with other state and federal requirements, including but not limited to debarment and suspension status, and standing with the secretary of state, if applicable.

(b) At any time when completing the pre-enrollment risk assessment, if the commissioner determines that the potential agency does not have a history of performing similar duties, the potential agency does not demonstrate the capability and capacity to perform the duties at the scale and pace required, or the results of the financial information review raise concern, then the commissioner may deem the potential agency ineligible and deny or rescind enrollment. A potential agency may appeal a decision regarding its eligibility in writing within 30 business days. The commissioner must notify each potential agency of the commissioner's final decision regarding its eligibility.

(c) This subdivision is effective July 1, 2025. Any housing stabilization services provider enrolled before July 1, 2025, that billed for services on or after January 1, 2024, must complete the pre-enrollment risk assessment on a schedule determined by the commissioner and no later than July 1, 2026, to remain eligible. Any provider enrolled before July 1, 2025, that has not billed for services on or after January 1, 2024, must complete the pre-enrollment risk assessment to remain eligible.

Subd. 6b. **Requirements for provider enrollment.** (a) Effective January 1, 2027, to enroll as a housing stabilization services provider agency, an agency must require all owners of the agency who are active in the day-to-day management and operations of the agency and managerial and supervisory employees to complete compliance training before applying for enrollment and every three years thereafter. Mandatory compliance training format and content must be determined by the commissioner and must include the following topics:

(1) state and federal program billing, documentation, and service delivery requirements;

(2) enrollment requirements;

(3) provider program integrity, including fraud prevention, detection, and penalties;

(4) fair labor standards;

(5) workplace safety requirements; and

(6) recent changes in service requirements.

(b) New owners active in day-to-day management and operations of the agency and new managerial and supervisory employees must complete compliance training under this subdivision to be employed by or conduct management and operations activities for the agency. If an individual moves to another housing stabilization services provider agency and serves in a similar ownership or employment capacity, the individual is not required to repeat the training required under this subdivision if the individual documents completion of the training within the past three years.

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(c) Any housing stabilization services provider agency enrolled before January 1, 2027, must complete the compliance training by January 1, 2028, and every three years thereafter.

**Subd. 7. Housing support supplemental service rates.** Supplemental service rates for individuals in settings according to sections 144D.025, 256I.04, subdivision 3, paragraph (a), clause (3), and 256I.05, subdivision 1g, shall be reduced by one-half over a two-year period. This reduction only applies to supplemental service rates for individuals eligible for housing stabilization services under this section.

**Subd. 8. Documentation requirements.** (a) An agency must document delivery of all services. The agency must collect and maintain the required information either electronically or in paper form and must produce the documents containing the information upon request by the commissioner.

(b) Documentation of a delivered service must be in English and must be legible according to the standard of a reasonable person.

(c) If the service is reimbursed at an hourly or specified minute-based rate, each documentation of the provision of a service, unless otherwise specified, must include:

(1) the full name of the service recipient;

(2) the date the documentation occurred;

(3) the day, month, and year the service was provided;

(4) the start and stop times with a.m. and p.m. designations, except for housing consultation services;

(5) the service name or description of the service provided for each date of service;

(6) the name, signature, and title, if any, of the employee of the agency that provided the service. If the service is provided by multiple employees, the agency may designate an employee responsible for verifying services and completing the documentation required by this paragraph;

(7) the signature of the service recipient and a statement that the recipient's signature is verification of the accuracy of the service documentation; and

(8) a statement that it is a federal crime to provide false information on housing stabilization services billings for medical assistance payments.

**Subd. 9. Service limits.** (a) Housing stabilization services must not exceed the limits in clauses (1) to (4):

(1) housing transition services are limited to 100 hours annually per recipient and are not billable when a recipient is concurrently receiving housing and tenancy sustaining services;

(2) housing and tenancy sustaining services are limited to 100 hours annually per recipient and are not billable when a recipient is concurrently receiving housing transition services;

(3) housing consultation services are available once annually per recipient and must be provided in person. Additional sessions of housing consultation services may be authorized by the commissioner if the recipient becomes homeless, the recipient experiences a significant change in condition that impacts the recipient's housing, or the recipient requests an update or change to the recipient's plan; and

(4) housing transition costs are limited to \$3,000 annually.

(b) Remote support cannot be used for more than a total of 20 percent of all housing transition services and housing and tenancy sustaining services provided to a recipient in a calendar month and is limited to audio-only and accessible video-based platforms. A recipient may refuse, stop, or suspend the use of remote support at any time.

**Subd. 10. Service limit exceptions.** If a recipient requires services exceeding the limits described in subdivision 9, a provider may request authorization for additional hours in a format prescribed by the commissioner. Requests must specify the number of additional hours being requested to meet the recipient's needs and include sufficient documentation to justify the increase to billable hours. Exceptions to service limits are not allowed on the sole basis of changing providers and are limited to recipients who:

(1) become or are at risk of becoming homeless or institutionalized due to a significant change in condition;

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- (2) have a history of long-term homelessness;
- (3) have a history of domestic violence; or
- (4) have a criminal background that is a barrier to obtaining housing.

*Laws 2025, First Special Session chapter 3, article 18, section 3*

Sec. 3. **DIRECTION TO COMMISSIONER; INDIAN HEALTH SERVICE ENCOUNTER RATE.**

The commissioner of human services must submit a state plan amendment to the Centers for Medicare and Medicaid Services authorizing housing services as a new service category eligible for reimbursement at the outpatient per-day rate approved by the Indian Health Service. This reimbursement is limited to services provided by facilities of the Indian Health Service and facilities owned or operated by a Tribe or Tribal organization. For the purposes of this section, "housing services" means housing stabilization services as described in Minnesota Statutes, section 256B.051, subdivision 5, paragraphs (a) to (d).