SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION

S.F. No. 3861

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DATE	D-PG	OFFICIAL STATUS
02/26/2026	6396	Introduction and first reading Referred to Human Services
03/17/2026	6690a	Comm report: To pass as amended and re-refer to Health and Human Services
03/23/2026		Comm report: To pass as amended and re-refer to Judiciary and Public Safety

A bill for an act

relating to human services; modifying medical assistance provider enrollment requirements for high-risk providers and certain home and community-based providers; making technical corrections; requiring compliance training for high-risk medical assistance providers; requiring disclosure of the use of consultants to prepare certain license applications; requiring commissioner of human services to release unredacted initial Optum reports; amending Minnesota Statutes 2024, sections 142B.01, subdivision 8; 245A.02, subdivision 5a; 245D.081, subdivision 3; 256B.073, subdivision 2; 256B.0949, subdivision 17; 256B.4912, subdivisions 12, 14, 15, by adding a subdivision; Minnesota Statutes 2025 Supplement, sections 245A.04, subdivisions 1, 7; 245A.05; 256B.04, subdivision 21; 256B.051, subdivision 6; 256B.0701, subdivision 9; 256B.0759, subdivision 4; 256B.0949, subdivision 16; 256B.4912, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 256B; repealing Minnesota Statutes 2025 Supplement, sections 256B.051, subdivision 6b; 256B.0701, subdivision 11.

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

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

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

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

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

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

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

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

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

2.6 (b) Controlling individual does not include:

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

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

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

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

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

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

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

2.27 (c) For purposes of this subdivision, "managerial official" means an individual who has
2.28 the decision-making authority related to the operation of the program, and the responsibility
2.29 for the ongoing management of or direction of the policies, services, or employees of the
2.30 program. A site director who has no ownership interest in the program is not considered to
2.31 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

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

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

4.9 Sec. 3. Minnesota Statutes 2025 Supplement, section 245A.04, subdivision 1, is amended
4.10 to read:

4.11 Subdivision 1. **Application for licensure.** (a) An individual, organization, or government
4.12 entity that is subject to licensure under section 245A.03 must apply for a license. The
4.13 application must be made on the forms and in the manner prescribed by the commissioner.
4.14 The commissioner shall provide the applicant with instruction in completing the application
4.15 and provide information about the rules and requirements of other state agencies that affect
4.16 the applicant. An applicant seeking licensure in Minnesota with headquarters outside of
4.17 Minnesota must have a program office located within 30 miles of the Minnesota border.
4.18 An applicant who intends to buy or otherwise acquire a program or services licensed under
4.19 this chapter that is owned by another license holder must apply for a license under this
4.20 chapter and comply with the application procedures in this section and section 245A.043.

4.21 The commissioner shall act on the application within 90 working days after a complete
4.22 application and any required reports have been received from other state agencies or
4.23 departments, counties, municipalities, or other political subdivisions. The commissioner
4.24 shall not consider an application to be complete until the commissioner receives all of the
4.25 required information. If the applicant or a controlling individual is the subject of a pending
4.26 administrative, civil, or criminal investigation, the application is not complete until the
4.27 investigation has closed or the related legal proceedings are complete.

4.28 When the commissioner receives an application for initial licensure that is incomplete
4.29 because the applicant failed to submit required documents or that is substantially deficient
4.30 because the documents submitted do not meet licensing requirements, the commissioner
4.31 shall provide the applicant written notice that the application is incomplete or substantially
4.32 deficient. In the written notice to the applicant the commissioner shall identify documents
4.33 that are missing or deficient and give the applicant 45 days to resubmit a second application
4.34 that is substantially complete. An applicant's failure to submit a substantially complete

5.1 application after receiving notice from the commissioner is a basis for license denial under
5.2 section 245A.043.

5.3 (b) An application for licensure must identify all controlling individuals as defined in
5.4 section 245A.02, subdivision 5a, and must designate one individual to be the authorized
5.5 agent. The application must be signed by the authorized agent and must include the authorized
5.6 agent's first, middle, and last name; mailing address; and email address. By submitting an
5.7 application for licensure, the authorized agent consents to electronic communication with
5.8 the commissioner throughout the application process. The authorized agent must be
5.9 authorized to accept service on behalf of all of the controlling individuals. A government
5.10 entity that holds multiple licenses under this chapter may designate one authorized agent
5.11 for all licenses issued under this chapter or may designate a different authorized agent for
5.12 each license. Service on the authorized agent is service on all of the controlling individuals.
5.13 It is not a defense to any action arising under this chapter that service was not made on each
5.14 controlling individual. The designation of a controlling individual as the authorized agent
5.15 under this paragraph does not affect the legal responsibility of any other controlling individual
5.16 under this chapter.

5.17 (c) An applicant or license holder must have a policy that prohibits license holders,
5.18 employees, subcontractors, and volunteers, when directly responsible for persons served
5.19 by the program, from abusing prescription medication or being in any manner under the
5.20 influence of a chemical that impairs the individual's ability to provide services or care. The
5.21 license holder must train employees, subcontractors, and volunteers about the program's
5.22 drug and alcohol policy before the employee, subcontractor, or volunteer has direct contact,
5.23 as defined in section 245C.02, subdivision 11, with a person served by the program.

5.24 (d) An applicant and license holder must have a program grievance procedure that permits
5.25 persons served by the program and their authorized representatives to bring a grievance to
5.26 the highest level of authority in the program.

5.27 (e) The commissioner may limit communication during the application process to the
5.28 authorized agent or the controlling individuals identified on the license application and for
5.29 whom a background study was initiated under chapter 245C. Upon implementation of the
5.30 provider licensing and reporting hub, applicants and license holders must use the hub in the
5.31 manner prescribed by the commissioner. The commissioner may require the applicant,
5.32 except for child foster care, to demonstrate competence in the applicable licensing
5.33 requirements by successfully completing a written examination. The commissioner may
5.34 develop a prescribed written examination format.

6.1 (f) When an applicant is an individual, the applicant must provide:

6.2 (1) the applicant's taxpayer identification numbers including the Social Security number
6.3 or Minnesota tax identification number, and federal employer identification number if the
6.4 applicant has employees;

6.5 (2) at the request of the commissioner, a copy of the most recent filing with the secretary
6.6 of state that includes the complete business name, if any;

6.7 (3) if doing business under a different name, the doing business as (DBA) name, as
6.8 registered with the secretary of state;

6.9 (4) if applicable, the applicant's National Provider Identifier (NPI) number and Unique
6.10 Minnesota Provider Identifier (UMPI) number; and

6.11 (5) at the request of the commissioner, the notarized signature of the applicant or
6.12 authorized agent.

6.13 (g) When an applicant is an organization, the applicant must provide:

6.14 (1) the applicant's taxpayer identification numbers including the Minnesota tax
6.15 identification number and federal employer identification number;

6.16 (2) at the request of the commissioner, a copy of the most recent filing with the secretary
6.17 of state that includes the complete business name, and if doing business under a different
6.18 name, the doing business as (DBA) name, as registered with the secretary of state;

6.19 (3) the first, middle, and last name, and address for all individuals who will be controlling
6.20 individuals, including all officers, owners, and managerial officials as defined in section
6.21 245A.02, subdivision 5a, and the date that the background study was initiated by the applicant
6.22 for each controlling individual;

6.23 (4) if applicable, the applicant's NPI number and UMPI number;

6.24 (5) the documents that created the organization and that determine the organization's
6.25 internal governance and the relations among the persons that own the organization, have
6.26 an interest in the organization, or are members of the organization, in each case as provided
6.27 or authorized by the organization's governing statute, which may include a partnership
6.28 agreement, bylaws, articles of organization, organizational chart, and operating agreement,
6.29 or comparable documents as provided in the organization's governing statute; and

6.30 (6) the notarized signature of the applicant or authorized agent.

6.31 (h) When the applicant is a government entity, the applicant must provide:

7.1 (1) the name of the government agency, political subdivision, or other unit of government
7.2 seeking the license and the name of the program or services that will be licensed;

7.3 (2) the applicant's taxpayer identification numbers including the Minnesota tax
7.4 identification number and federal employer identification number;

7.5 (3) a letter signed by the manager, administrator, or other executive of the government
7.6 entity authorizing the submission of the license application; and

7.7 (4) if applicable, the applicant's NPI number and UMPI number.

7.8 (i) At the time of application for licensure or renewal of a license under this chapter, the
7.9 applicant or license holder must acknowledge on the form provided by the commissioner
7.10 if the applicant or license holder elects to receive any public funding reimbursement from
7.11 the commissioner for services provided under the license that:

7.12 (1) the applicant's or license holder's compliance with the provider enrollment agreement
7.13 or registration requirements for receipt of public funding may be monitored by the
7.14 commissioner as part of a licensing investigation or licensing inspection; and

7.15 (2) noncompliance with the provider enrollment agreement or registration requirements
7.16 for receipt of public funding that is identified through a licensing investigation or licensing
7.17 inspection, or noncompliance with a licensing requirement that is a basis of enrollment for
7.18 reimbursement for a service, may result in:

7.19 (i) a correction order or a conditional license under section 245A.06, or sanctions under
7.20 section 245A.07;

7.21 (ii) nonpayment of claims submitted by the license holder for public program
7.22 reimbursement;

7.23 (iii) recovery of payments made for the service;

7.24 (iv) disenrollment in the public payment program; or

7.25 (v) other administrative, civil, or criminal penalties as provided by law.

7.26 (j) An applicant or license holder who acknowledges under paragraph (i) that the applicant
7.27 or license holder elects to receive any publicly funded reimbursement from the commissioner
7.28 for services provided under the license that are designated by the commissioner as high-risk
7.29 under section 256B.044, subdivision 1, must provide an attestation with the notarized
7.30 signature of the applicant or authorized agent stating whether the applicant or authorized
7.31 agent received from an unaffiliated business or consultant any assistance preparing:

7.32 (1) the application;

8.1 (2) the renewal;

8.2 (3) any documentation or written policies submitted with the application;

8.3 (4) any documentation or written policies submitted with the renewal; or

8.4 (5) any documentation or written policies maintained as a requirement of licensure or
8.5 enrollment as a medical assistance provider.

8.6 Sec. 4. Minnesota Statutes 2025 Supplement, section 245A.04, subdivision 7, is amended
8.7 to read:

8.8 Subd. 7. **Grant of license; license extension.** (a) If the commissioner determines that
8.9 the program complies with all applicable rules and laws, the commissioner shall issue a
8.10 license consistent with this section or, if applicable, a temporary change of ownership license
8.11 under section 245A.043. At minimum, the license shall state:

8.12 (1) the name of the license holder;

8.13 (2) the address of the program;

8.14 (3) the effective date and expiration date of the license;

8.15 (4) the type of license and the specific service the license holder is licensed to provide;

8.16 (5) the maximum number and ages of persons that may receive services from the program;
8.17 and

8.18 (6) any special conditions of licensure.

8.19 (b) The commissioner may issue a license for a period not to exceed two years if:

8.20 (1) the commissioner is unable to conduct the observation required by subdivision 4,
8.21 paragraph (a), clause (3), because the program is not yet operational;

8.22 (2) certain records and documents are not available because persons are not yet receiving
8.23 services from the program; and

8.24 (3) the applicant complies with applicable laws and rules in all other respects.

8.25 (c) A decision by the commissioner to issue a license does not guarantee that any person
8.26 or persons will be placed or cared for in the licensed program.

8.27 (d) Except as provided in paragraphs (i) and (j), the commissioner shall not issue a
8.28 license if the applicant, license holder, or an affiliated controlling individual has:

8.29 (1) been disqualified and the disqualification was not set aside and no variance has been
8.30 granted;

9.1 (2) been denied a license under this chapter or chapter 142B within the past two years;

9.2 (3) had a license issued under this chapter or chapter 142B revoked within the past five
9.3 years; or

9.4 (4) failed to submit the information required of an applicant under subdivision 1,
9.5 paragraph (f), (g), ~~or~~ (h)<u>, or (j)</u>, after being requested by the commissioner.

9.6 When a license issued under this chapter or chapter 142B is revoked, the license holder
9.7 and each affiliated controlling individual with a revoked license may not hold any license
9.8 under chapter 245A for five years following the revocation, and other licenses held by the
9.9 applicant or license holder or licenses affiliated with each controlling individual shall also
9.10 be revoked.

9.11 (e) Notwithstanding paragraph (d), the commissioner may elect not to revoke a license
9.12 affiliated with a license holder or controlling individual that had a license revoked within
9.13 the past five years if the commissioner determines that (1) the license holder or controlling
9.14 individual is operating the program in substantial compliance with applicable laws and rules
9.15 and (2) the program's continued operation is in the best interests of the community being
9.16 served.

9.17 (f) Notwithstanding paragraph (d), the commissioner may issue a new license in response
9.18 to an application that is affiliated with an applicant, license holder, or controlling individual
9.19 that had an application denied within the past two years or a license revoked within the past
9.20 five years if the commissioner determines that (1) the applicant or controlling individual
9.21 has operated one or more programs in substantial compliance with applicable laws and rules
9.22 and (2) the program's operation would be in the best interests of the community to be served.

9.23 (g) In determining whether a program's operation would be in the best interests of the
9.24 community to be served, the commissioner shall consider factors such as the number of
9.25 persons served, the availability of alternative services available in the surrounding
9.26 community, the management structure of the program, whether the program provides
9.27 culturally specific services, and other relevant factors.

9.28 (h) The commissioner shall not issue or reissue a license under this chapter if an individual
9.29 living in the household where the services will be provided as specified under section
9.30 245C.03, subdivision 1, has been disqualified and the disqualification has not been set aside
9.31 and no variance has been granted.

9.32 (i) Pursuant to section 245A.07, subdivision 1, paragraph (b), when a license issued
9.33 under this chapter has been suspended or revoked and the suspension or revocation is under

10.1 appeal, the program may continue to operate pending a final order from the commissioner.
10.2 If the license under suspension or revocation will expire before a final order is issued, a
10.3 temporary provisional license may be issued provided any applicable license fee is paid
10.4 before the temporary provisional license is issued.

10.5 (j) Notwithstanding paragraph (i), when a revocation is based on the disqualification of
10.6 a controlling individual or license holder, and the controlling individual or license holder
10.7 is ordered under section 245C.17 to be immediately removed from direct contact with
10.8 persons receiving services or is ordered to be under continuous, direct supervision when
10.9 providing direct contact services, the program may continue to operate only if the program
10.10 complies with the order and submits documentation demonstrating compliance with the
10.11 order. If the disqualified individual fails to submit a timely request for reconsideration, or
10.12 if the disqualification is not set aside and no variance is granted, the order to immediately
10.13 remove the individual from direct contact or to be under continuous, direct supervision
10.14 remains in effect pending the outcome of a hearing and final order from the commissioner.

10.15 (k) Unless otherwise specified by statute, all licenses issued under this chapter expire
10.16 at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must
10.17 comply with the requirements in section 245A.10 and be reissued a new license to operate
10.18 the program or the program must not be operated after the expiration date. Adult foster care,
10.19 family adult day services, child foster residence setting, and community residential services
10.20 license holders must apply for and be granted a new license to operate the program or the
10.21 program must not be operated after the expiration date. Upon implementation of the provider
10.22 licensing and reporting hub, licenses may be issued each calendar year.

10.23 (l) The commissioner shall not issue or reissue a license under this chapter if it has been
10.24 determined that a Tribal licensing authority has established jurisdiction to license the program
10.25 or service.

10.26 (m) The commissioner of human services may coordinate and share data with the
10.27 commissioner of children, youth, and families to enforce this section.

10.28 (n) For substance use disorder treatment programs, for the purposes of paragraph (a),
10.29 clause (5), the maximum number of persons who may receive services from the program
10.30 includes persons served at satellite locations.

10.31 Sec. 5. Minnesota Statutes 2025 Supplement, section 245A.05, is amended to read:

10.32 **245A.05 DENIAL OF APPLICATION.**

10.33 (a) The commissioner may deny a license if an applicant or controlling individual:

(1) fails to submit a substantially complete application after receiving notice from the commissioner under section 245A.04, subdivision 1;

(2) fails to comply with applicable laws or rules;

(3) knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license or during an investigation;

(4) has a disqualification that has not been set aside under section 245C.22 and no variance has been granted;

(5) has an individual living in the household who received a background study under section 245C.03, subdivision 1, paragraph (a), clause (2), who has a disqualification that has not been set aside under section 245C.22, and no variance has been granted;

(6) is associated with an individual who received a background study under section 245C.03, subdivision 1, paragraph (a), clause (6), who may have unsupervised access to children or vulnerable adults, and who has a disqualification that has not been set aside under section 245C.22, and no variance has been granted;

(7) fails to comply with section 245A.04, subdivision 1, paragraph (f) ~~or~~, (g), or (j);

(8) fails to demonstrate competent knowledge as required by section 245A.04, subdivision 6;

(9) has a history of noncompliance as a license holder or controlling individual with applicable laws or rules, including but not limited to this chapter and chapters 142E and 245C;

(10) is prohibited from holding a license according to section 245.095; or

(11) is the subject of a pending administrative, civil, or criminal investigation.

(b) An applicant whose application has been denied by the commissioner must be given notice of the denial, which must state the reasons for the denial in plain language. Notice must be given by certified mail, by personal service, or through the provider licensing and reporting hub. The notice must state the reasons the application was denied and must inform the applicant of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the commissioner in writing by certified mail, by personal service, or through the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the commissioner within 20 calendar days after the applicant received the notice of denial. If

an appeal request is made by personal service, it must be received by the commissioner within 20 calendar days after the applicant received the notice of denial. If the order is issued through the provider hub, the appeal must be received by the commissioner within 20 calendar days from the date the commissioner issued the order through the hub. Section 245A.08 applies to hearings held to appeal the commissioner's denial of an application.

Sec. 6. 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. 7. 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 Code of Federal Regulations, title 42, section 455, subpart E, and sections 256B.044 to 256B.0445.

~~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~~

16.1 ~~provider of five percent or higher, consent to criminal background checks, including~~
16.2 ~~fingerprinting, when required to do so under state law or by a determination by the~~
16.3 ~~commissioner or the Centers for Medicare and Medicaid Services that a provider is designated~~
16.4 ~~high-risk for fraud, waste, or abuse.~~

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

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

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

16.28 ~~(m) The Department of Human Services may require a provider to purchase a surety~~
16.29 ~~bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment~~
16.30 ~~if: (1) the provider fails to demonstrate financial viability, (2) the department determines~~
16.31 ~~there is significant evidence of or potential for fraud and abuse by the provider, or (3) the~~
16.32 ~~provider or category of providers is designated high-risk pursuant to paragraph (f) and as~~
16.33 ~~per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in an~~
16.34 ~~amount of $100,000 or ten percent of the provider's payments from Medicaid during the~~
16.35 ~~immediately preceding 12 months, whichever is greater. The surety bond must name the~~

17.1 ~~Department of Human Services as an obligee and must allow for recovery of costs and fees~~
17.2 ~~in pursuing a claim on the bond. This paragraph does not apply if the provider currently~~
17.3 ~~maintains a surety bond under the requirements in section 256B.051, 256B.0659, 256B.0701,~~
17.4 ~~or 256B.85.~~

17.5 Sec. 8. **[256B.044] PROVIDER ENROLLMENT.**

17.6 Subdivision 1. **Designating categorical risk levels.** (a) The commissioner shall publish
17.7 in the Minnesota Health Care Program Provider Manual a list of provider types designated
17.8 "limited-risk," "moderate-risk," or "high-risk," based on the criteria and standards used by
17.9 the Centers for Medicare and Medicaid Services (CMS) to designate Medicare providers
17.10 in Code of Federal Regulations, title 42, section 424.518.

17.11 (b) The list and criteria are not subject to the requirements of chapter 14, and section
17.12 14.386 does not apply.

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

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

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

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

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

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

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

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

18.4 (3) the provider or category of providers is designated high-risk pursuant to subdivision
18.5 1 and Code of Federal Regulations, title 42, section 455.450.

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

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

18.12 Subd. 6. **Required permission to conduct on-site inspection.** As a condition of
18.13 enrollment in medical assistance, the commissioner shall require that a provider designated
18.14 moderate-risk or high-risk by CMS or the commissioner permit CMS, CMS's agents, or
18.15 CMS's designated contractors and the state agency, the state agency's agents, or the state
18.16 agency's designated contractors to conduct unannounced on-site inspections of any provider
18.17 location.

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

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

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

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

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

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

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

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

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

19.10 Sec. 9. **[256B.0441] PROVIDER REVALIDATION.**

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

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

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

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

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

19.20 Subd. 2. **Revalidation procedures.** The commissioner shall conduct revalidation as
19.21 follows:

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

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

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

20.1 Sec. 10. **[256B.0442] PROVIDER ENROLLMENT SUSPENSIONS AND**
20.2 **TERMINATIONS.**

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

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

20.9 Subd. 2. **Commissioner's authority to revoke enrollment of certain providers for**
20.10 **lack of documentation.** (a) The commissioner may revoke the enrollment of an ordering
20.11 or rendering provider for a period of not more than one year if the provider fails to maintain
20.12 and, upon request from the commissioner, provide access to documentation relating to
20.13 written orders or requests for payment for durable medical equipment, certifications for
20.14 home health services, or referrals for other items or services written or ordered by the
20.15 provider, when the commissioner has identified a pattern of a lack of documentation. A
20.16 pattern means a failure to maintain documentation or provide access to documentation on
20.17 more than one occasion.

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

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

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

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

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

20.31 (3) serves primarily a pediatric population.

21.1 Sec. 11. **[256B.0443] PROVIDER PAYMENT WITHHOLDS UPON INITIAL**
21.2 **ENROLLMENT.**

21.3 (a) If the commissioner or the Centers for Medicare and Medicaid Services designates
21.4 a provider type as high-risk, the commissioner may withhold payment from providers within
21.5 that category upon initial enrollment for a 90-day period.

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

21.8 Sec. 12. **[256B.0444] ADDITIONAL PROVIDER ENROLLMENT REQUIREMENTS**
21.9 **FOR HIGH-RISK PROVIDERS.**

21.10 Subdivision 1. **Applicability.** This section applies to any agency that provides a service
21.11 designated by the commissioner as high-risk under section 256B.044, subdivision 1. For
21.12 purposes of this section, "agency" means the legal entity that is applying to be or is enrolled
21.13 with Minnesota health care programs as a medical assistance provider according to Minnesota
21.14 Rules, part 9505.0195.

21.15 Subd. 2. **Mandatory training compliance.** (a) Effective January 1, 2027, before applying
21.16 for enrollment or reenrollment as a medical assistance provider, an agency applying to
21.17 provide services designated by the commissioner as high-risk must require all owners of
21.18 the agency who are active in the day-to-day management and operations of the agency and
21.19 managerial and supervisory employees to complete compliance training. All individuals
21.20 who must complete training under this subdivision must repeat the training prior to
21.21 revalidation of the agency as a medical assistance provider.

21.22 (b) New owners active in day-to-day management and operations of the agency and new
21.23 managerial and supervisory employees of the agency must complete compliance training
21.24 under this subdivision within 30 calendar days of becoming an owner of or employed by
21.25 the agency and prior to conducting any management and operations activities for the agency.
21.26 If an individual moves to another agency providing the same service and serves in a similar
21.27 ownership or employment capacity, the individual is not required to repeat the training
21.28 required under this subdivision. If the individual chooses not to repeat the compliance
21.29 training, the individual must provide the agency with documentation proving the individual
21.30 completed the compliance training within the provider revalidation schedule for the relevant
21.31 provider type as determined by the commissioner under section 256B.0441.

22.1 (c) The commissioner must determine the format and content of the compliance training.
22.2 The training must include the following topics, adapted as necessary for each provider type
22.3 subject to the requirements of this subdivision:

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

22.5 (2) enrollment requirements;

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

22.7 (4) fair labor standards;

22.8 (5) workplace safety requirements; and

22.9 (6) recent changes in service requirements.

22.10 Subd. 3. **Individual provider number.** (a) Effective January 1, 2027, all individuals
22.11 subject to a background study as a result of being employed by or an owner of a high-risk
22.12 agency must enroll individually as a medical assistance provider.

22.13 (b) The commissioner must issue a unique Minnesota provider identifier to each
22.14 individual who satisfies the background study requirements, satisfies the individual
22.15 enrollment requirements, and does not have either a national provider identifier or a unique
22.16 Minnesota provider identifier. The commissioner must ensure that no individual is issued
22.17 multiple unique Minnesota provider identifiers. If the commissioner mistakenly issues
22.18 multiple unique Minnesota provider identifiers to the same individual, the commissioner
22.19 must provide a means for the numbers to be consolidated.

22.20 (c) If an individual provides false or misleading information to the commissioner in an
22.21 attempt to cause the commissioner to issue to the individual an additional unique Minnesota
22.22 provider identifier, the commissioner may terminate the enrollment of the individual.

22.23 Subd. 4. **Required use of an electronic visit verification system.** Effective January 1,
22.24 2027, an individual providing a high-risk service must electronically verify the provision
22.25 of the services using an electronic visit verification system meeting the requirements of
22.26 section 256B.073.

22.27 Subd. 5. **Signatures required for provision of service verifications.** (a) Effective
22.28 January 1, 2027, an individual providing a high-risk service must sign and obtain the
22.29 signature of the service recipient, or of the service recipient's representative, on a provision
22.30 of service verification form. The provision of service verification form must include a
22.31 statement that by signing the form, the signatory is attesting to the accuracy of all data
22.32 entered in the electronic visit verification system. The provision of service verification form

23.1 must also include a statement that it is a federal crime to provide false information regarding
23.2 the provision of medical assistance services.

23.3 (b) The commissioner must determine a minimum frequency at which the required
23.4 signatures on a provision of service verification form must be obtained.

23.5 Subd. 6. **Documentation of travel time.** Effective January 1, 2027, an individual
23.6 providing a high-risk service must document any travel or driving time that is eligible for
23.7 reimbursement and for which the individual or high-risk agency seeks a medical assistance
23.8 payment. The documentation must include:

23.9 (1) start and stop times with a.m. and p.m. designations;

23.10 (2) the origination site; and

23.11 (3) the destination site.

23.12 Sec. 13. **[256B.0445] ADDITIONAL PROVIDER ENROLLMENT REQUIREMENTS**
23.13 **FOR SPECIFIC PROVIDER TYPES.**

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

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

23.27 (c) At the time of initial enrollment or reenrollment, durable medical equipment providers
23.28 or suppliers defined in paragraph (a) must purchase a surety bond of $50,000. If a revalidating
23.29 provider's Medicaid revenue in the previous calendar year is up to and including $300,000,
23.30 the provider agency must purchase a surety bond of $50,000. If a revalidating provider's
23.31 Medicaid revenue in the previous calendar year is over $300,000, the provider agency must
23.32 purchase a surety bond of $100,000. The surety bond must allow for recovery of costs and
23.33 fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions

24.1 from a surety bond must occur within six years from the date the debt is affirmed by a final
24.2 agency decision. An agency decision is final when the right to appeal the debt has been
24.3 exhausted or the time to appeal has expired under section 256B.064.

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

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

24.13 Sec. 14. Minnesota Statutes 2025 Supplement, section 256B.051, subdivision 6, is amended
24.14 to read:

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

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

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

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

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

24.25 (5) provides at the time of enrollment, reenrollment, and revalidation in a format
24.26 determined by the commissioner, proof of surety bond coverage for each business location
24.27 providing services. Upon new enrollment, or if the provider's medical assistance revenue
24.28 in the previous calendar year is $300,000 or less, the provider agency must purchase a surety
24.29 bond of $50,000. If the provider's medical assistance revenue in the previous year is over
24.30 $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond
24.31 must be in a form approved by the commissioner, must be renewed annually, and must
24.32 allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain
24.33 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 section 256B.0444, subdivision ~~6b~~ 2.

Sec. 15. Minnesota Statutes 2025 Supplement, section 256B.0701, subdivision 9, is amended to read:

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

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

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

(7) completes compliance training as required under section 256B.0444, subdivision ~~11~~ 2; and

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

Sec. 16. Minnesota Statutes 2024, section 256B.073, subdivision 2, is amended to read:

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

(b) "Electronic visit verification" means the electronic documentation of the:

(1) type of service performed;

(2) individual receiving the service;

(3) date of the service;

(4) location of the service delivery;

(5) individual providing the service; and

(6) time the service begins and ends.

(c) "Electronic visit verification system" means a system that provides electronic verification of services that complies with the 21st Century Cures Act, Public Law 114-255, and the requirements of subdivision 3.

(d) "Service" ~~means one of the following~~ includes:

(1) personal care assistance services as defined in section 256B.0625, subdivision 19a, and provided according to section 256B.0659;

(2) community first services and supports under section 256B.85;

(3) home health services under section 256B.0625, subdivision 6a; ~~or~~

(4) other medical supplies and equipment or home and community-based services that are required to be electronically verified by the 21st Century Cures Act, Public Law 114-255~~.~~;

(5) services provided by a provider type designated by the commissioner as high-risk under section 256B.044, subdivision 1; and

(6) home and community-based services reimbursed at an hourly or specified minute-based rate and provided according to a federally approved waiver plan as authorized under chapter 256S and sections 256B.0913, 256B.092, and 256B.49.

Sec. 17. Minnesota Statutes 2025 Supplement, section 256B.0759, subdivision 4, is amended to read:

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

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

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

(d) Effective January 1, 2021, and contingent on annual federal approval, managed care 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. 18. 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.0445, 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;

(5) demonstrate that while enrolled or seeking enrollment as a Minnesota health care program provider the agency did not have a lead agency contract or provider agreement discontinued because of a conviction of fraud; or did not have an owner, board member, or manager fail a state or federal criminal background check or appear on the list of excluded

29.1 individuals or entities maintained by the federal Department of Human Services Office of
29.2 Inspector General;

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

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

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

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

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

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

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

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

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

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

29.30 (16) provide required EIDBI intervention observation and direction at least once per
29.31 month. Notwithstanding subdivision 13, paragraph (l), required EIDBI intervention
29.32 observation and direction under this clause may be conducted via telehealth provided that

30.1 no more than two consecutive monthly required EIDBI intervention observation and direction
30.2 sessions under this clause are conducted via telehealth.

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

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

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

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

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

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

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

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

30.21 Sec. 19. Minnesota Statutes 2024, section 256B.0949, subdivision 17, is amended to read:

30.22 Subd. 17. **Provider shortage; authority for exceptions.** (a) In consultation with the
30.23 Early Intensive Developmental and Behavioral Intervention Advisory Council and
30.24 stakeholders, including agencies, professionals, parents of people with ASD or a related
30.25 condition, and advocacy organizations, the commissioner shall determine if a shortage of
30.26 EIDBI providers exists. For the purposes of this subdivision, "shortage of EIDBI providers"
30.27 means a lack of availability of providers who meet the EIDBI provider qualification
30.28 requirements under subdivision 15 that results in the delay of access to timely services under
30.29 this section, or that significantly impairs the ability of a provider agency to have sufficient
30.30 providers to meet the requirements of this section. The commissioner shall consider
30.31 geographic factors when determining the prevalence of a shortage. The commissioner may
30.32 determine that a shortage exists only in a specific region of the state, multiple regions of

31.1 the state, or statewide. The commissioner shall also consider the availability of various types
31.2 of treatment modalities covered under this section.

31.3 (b) The commissioner, in consultation with the Early Intensive Developmental and
31.4 Behavioral Intervention Advisory Council and stakeholders, must establish processes and
31.5 criteria for granting an exception under this paragraph. The commissioner may grant an
31.6 exception only if the exception would not compromise a person's safety and not diminish
31.7 the effectiveness of the treatment. The commissioner may establish an expiration date for
31.8 an exception granted under this paragraph. The commissioner may grant an exception for
31.9 the following:

31.10 (1) EIDBI provider qualifications under this section;

31.11 (2) medical assistance provider enrollment requirements under ~~section 256B.04,~~
31.12 ~~subdivision 21~~ sections 256B.044 to 256B.0445; or

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

31.14 (c) If the commissioner, in consultation with the Early Intensive Developmental and
31.15 Behavioral Intervention Advisory Council and stakeholders, determines that a shortage no
31.16 longer exists, the commissioner must submit a notice that a shortage no longer exists to the
31.17 chairs and ranking minority members of the senate and the house of representatives
31.18 committees with jurisdiction over health and human services. The commissioner must post
31.19 the notice for public comment for 30 days. The commissioner shall consider public comments
31.20 before submitting to the legislature a request to end the shortage declaration. The
31.21 commissioner shall not declare the shortage of EIDBI providers ended without direction
31.22 from the legislature to declare it ended.

31.23 Sec. 20. Minnesota Statutes 2025 Supplement, section 256B.4912, subdivision 1, is
31.24 amended to read:

31.25 Subdivision 1. **Provider qualifications.** (a) For the home and community-based waivers
31.26 providing services to seniors and individuals with disabilities under chapter 256S and
31.27 sections 256B.0913, 256B.092, and 256B.49, the commissioner shall establish:

31.28 (1) agreements with enrolled waiver service providers to ensure providers meet Minnesota
31.29 health care program requirements;

31.30 (2) regular reviews of provider qualifications, ~~and~~ including requests ~~of~~ for proof of
31.31 documentation; and

31.32 (3) processes to gather the necessary information to determine provider qualifications.

(b) A provider shall not require or coerce any service recipient to change waiver programs or move to a different location, consistent with the informed choice and independent living policies under section 256B.4905, subdivisions 1a, 2a, 3a, 7, and 8.

(c) For staff that provide direct contact, as defined in section 245C.02, subdivision 11, for services specified in the federally approved waiver plans, providers must meet the requirements of chapter 245C and maintain documentation of background study requests and results. This requirement also applies to consumer-directed community supports.

(d) Service owners and managerial officials overseeing the management or policies of services that provide direct contact as specified in the federally approved waiver plans must meet the requirements of chapter 245C prior to reenrollment or revalidation or, for new providers, prior to initial enrollment if they have not already done so as a part of service licensure requirements.

Sec. 21. Minnesota Statutes 2024, section 256B.4912, is amended by adding a subdivision to read:

Subd. 10a. **Individual provider identifier.** (a) Effective January 1, 2027, staff that provide direct contact, as defined in section 245C.02, subdivision 11, for services specified in the federally approved waiver plans must enroll individually with Minnesota health care programs as a medical assistance provider. This requirement also applies to consumer-directed community supports.

(b) For individuals enrolling individually under this subdivision, the commissioner must conform with the requirements of section 256B.0444, subdivision 3.

Sec. 22. Minnesota Statutes 2024, section 256B.4912, subdivision 12, is amended to read:

Subd. 12. **Home and community-based service documentation requirements.** (a) Unless the provider is required to use an electronic visit verification system authorized under section 256B.073, the provider must collect and maintain documentation ~~may be collected and maintained~~ electronically or in paper form ~~by providers and must be produced~~. The provider must produce all documentation 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 date the documentation occurred;

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

(3) the start and stop times with a.m. and p.m. designations, except for case management services as defined under chapter 256S and sections 256B.0913, subdivision 7; 256B.092, subdivision 1a; and 256B.49, subdivision 13;

(4) the service name or description of the service provided; and

(5) the name, individual provider identifier, signature, and title, if any, of the provider of service. If the service is provided by multiple staff members, the provider may designate a staff member responsible for verifying services and completing the documentation required by this paragraph.

(d) If the service is reimbursed at a daily rate or does not meet the requirements in paragraph (c), each documentation of the provision of a service, unless otherwise specified, must include:

(1) the date the documentation occurred;

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

(3) the service name or description of the service provided; and

(4) the name, individual provider identifier, signature, and title, if any, of the person providing the service. If the service is provided by multiple staff, the provider may designate a staff member responsible for verifying services and completing the documentation required by this paragraph. The designated staff member verifying the services must include in the documentation of the provision of a service the names and individual provider identifiers of all staff who provided the service.

Sec. 23. Minnesota Statutes 2024, section 256B.4912, subdivision 14, is amended to read:

Subd. 14. **Equipment and supply documentation requirements.** (a) ~~In addition to~~ An equipment and supply services provider must follow the requirements in subdivision 12, except for the requirement to provide an individual provider identifier. An equipment and supply services provider must also include for each documentation of the provision of a service ~~include~~:

(1) the recipient's assessed need for the equipment or supply;

(2) the reason the equipment or supply is not covered by the Medicaid state plan;

(3) the type and brand name of the equipment or supply delivered to or purchased by the recipient, including whether the equipment or supply was rented or purchased;

34.1 (4) the quantity of the equipment or supply delivered or purchased; and

34.2 (5) the cost of the equipment or supply if the amount paid for the service depends on
34.3 the cost.

34.4 (b) A provider must maintain a copy of the shipping invoice or a delivery service tracking
34.5 log or other documentation showing the date of delivery that proves the equipment or supply
34.6 was delivered to the recipient or a receipt if the equipment or supply was purchased by the
34.7 recipient.

34.8 Sec. 24. Minnesota Statutes 2024, section 256B.4912, subdivision 15, is amended to read:

34.9 Subd. 15. **Adult day service documentation and billing requirements.** (a) In addition
34.10 to the requirements in subdivision 12, a provider of adult day services as defined in section
34.11 245A.02, subdivision 2a, and licensed under Minnesota Rules, parts 9555.9600 to 9555.9730,
34.12 must maintain documentation of:

34.13 (1) a needs assessment and current plan of care according to section 245A.143,
34.14 subdivisions 4 to 7, or Minnesota Rules, part 9555.9700, for each recipient, if applicable;

34.15 (2) attendance records as specified under section 245A.14, subdivision 14, paragraph
34.16 (a), including the date of attendance with the day, month, and year; and the pickup and
34.17 drop-off time in hours and minutes with a.m. and p.m. designations;

34.18 (3) the monthly and quarterly program requirements in Minnesota Rules, part 9555.9710,
34.19 subparts 1, items E and H; 3; 4; and 6, if applicable;

34.20 (4) the name, individual provider identifier, and qualification of each registered physical
34.21 therapist, registered nurse, and registered dietitian who provides services to the adult day
34.22 services or nonresidential program; and

34.23 (5) the location where the service was provided. If the location is an alternate location
34.24 from the usual place of service, the documentation must include the address, or a description
34.25 if the address is not available, of both the origin site and destination site; the length of time
34.26 at the alternate location with a.m. and p.m. designations; and a list of participants who went
34.27 to the alternate location.

34.28 (b) A provider must not exceed the provider's licensed capacity. If a provider exceeds
34.29 the provider's licensed capacity, the ~~department~~ commissioner must recover all Minnesota
34.30 health care programs payments from the date the provider exceeded licensed capacity.

35.1 Sec. 25. **MANDATORY COMPLIANCE TRAINING FOR CURRENTLY**
35.2 **ENROLLED HIGH-RISK MEDICAL ASSISTANCE PROVIDERS.**

35.3 The owners and employees of any medical assistance provider agency subject to the
35.4 requirements of Minnesota Statutes, section 256B.0444, subdivision 2, and enrolled before
35.5 January 1, 2027, must complete initial compliance training by January 1, 2028. Owners and
35.6 employees of PCA and CFSS agencies who enrolled before January 1, 2027, and have
35.7 previously completed training under Minnesota Statutes, section 256B.0659, subdivision
35.8 21, paragraph (c), or 256B.85, subdivision 12, paragraph (c), are not subject to the initial
35.9 training requirements of this section but must repeat the compliance training prior to
35.10 revalidation as a medical assistance provider.

35.11 Sec. 26. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
35.12 **UNREDACTED INITIAL OPTUM REPORTS.**

35.13 (a) For the purposes of this section, "initial Optum reports" means the reports produced
35.14 by Optum, Inc., under contract with the Department of Human Services and announced in
35.15 the news release from the department on February 6, 2026.

35.16 (b) Notwithstanding any law to the contrary, the commissioner of human services must
35.17 immediately release the initial Optum reports to the public in the reports' entirety without
35.18 redactions or edits, except for redactions requested by Optum to protect proprietary
35.19 information.

35.20 **EFFECTIVE DATE.** This section is effective 14 days following final enactment.

35.21 Sec. 27. **REPEALER.**

35.22 Minnesota Statutes 2025 Supplement, sections 256B.051, subdivision 6b; and 256B.0701,
35.23 subdivision 11, are repealed.

256B.051 HOUSING STABILIZATION SERVICES.

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.

(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.

256B.0701 RECUPERATIVE CARE SERVICES.

Subd. 11. **Requirements for provider enrollment; compliance training.** (a) Effective January 1, 2027, to enroll as a recuperative care provider, a provider must require all owners of the provider who are active in the day-to-day management and operations of the agency and all 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 provider 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 provider. If an individual moves to another recuperative care provider 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.

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