

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

S.F. No. 4222

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DATE	D-PG	OFFICIAL STATUS
03/09/2026	6562	Introduction and first reading Referred to Health and Human Services
03/23/2026	6919	Author added Fateh
03/26/2026	7017a	Comm report: Amended, No recommendation, re-referred to Human Services
	7102	Chief author stricken, shown as co-author Abeler Chief author added Hoffman
	7103	Author added Wiklund
04/07/2026		Comm report: Amended, No recommendation, re-referred to Finance

1.1 A bill for an act

1.2 relating to human services; modifying requirements for provider enrollment in

1.3 medical assistance; modifying program integrity requirements for the medical

1.4 assistance program; directing the commissioner of human services to create a

1.5 medical assistance program integrity advisory board; directing the commissioner

1.6 of human services to make recommendations on provider enrollment standards,

1.7 modernizing program integrity infrastructure, and program integrity interventions;

1.8 directing the commissioner of human services to conduct audits; requiring reports;

1.9 making technical changes; authorizing rulemaking; appropriating money; amending

1.10 Minnesota Statutes 2024, sections 142B.01, subdivision 8; 245.095, by adding a

1.11 subdivision; 245A.02, subdivision 5a; 245D.081, subdivision 3; 256B.04,

1.12 subdivision 5; 256B.064, subdivisions 1b, 1d, 2, 3, 4, 5, by adding subdivisions;

1.13 256B.0949, subdivision 17; Minnesota Statutes 2025 Supplement, sections 15.013,

1.14 by adding a subdivision; 256B.04, subdivision 21; 256B.064, subdivision 1a;

1.15 256B.0759, subdivision 4; 256B.0949, subdivision 16; proposing coding for new

1.16 law in Minnesota Statutes, chapter 256B.

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

1.18 **ARTICLE 1**

1.19 **PROGRAM INTEGRITY REQUIREMENTS**

1.20 Section 1. Minnesota Statutes 2025 Supplement, section 15.013, is amended by adding a

1.21 subdivision to read:

1.22 Subd. 7. Exemption. This section does not apply to the medical assistance program

1.23 administered by the commissioner of human services.

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

2.1 Sec. 2. Minnesota Statutes 2024, section 245.095, is amended by adding a subdivision to
2.2 read:

2.3 Subd. 7. **Exemption.** Subdivision 5 does not apply to any individual or entity that receives
2.4 payments from medical assistance or provides goods or services for which payment is made
2.5 from medical assistance.

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

2.7 Sec. 3. Minnesota Statutes 2025 Supplement, section 256B.064, subdivision 1a, is amended
2.8 to read:

2.9 Subd. 1a. **Grounds for sanctions.** (a) The commissioner may impose sanctions against
2.10 any individual or entity that receives payments from medical assistance or provides goods
2.11 or services for which payment is made from medical assistance for any of the following:

2.12 (1) fraud, theft, or abuse in connection with the provision of goods and services to
2.13 recipients of public assistance for which payment is made from medical assistance;

2.14 (2) a pattern of presentment of false or duplicate claims or claims for services not
2.15 medically necessary;

2.16 (3) a pattern of making false statements of material facts for the purpose of obtaining
2.17 greater compensation than that to which the individual or entity is legally entitled;

2.18 (4) suspension or termination as a Medicare vendor;

2.19 (5) refusal to grant the state agency access during regular business hours to examine all
2.20 records necessary to disclose the extent of services provided to program recipients and
2.21 appropriateness of claims for payment;

2.22 (6) failure to repay an overpayment or a fine finally established under this section;

2.23 (7) failure to correct errors in the maintenance of health service or financial records for
2.24 which a fine was imposed or after issuance of a warning by the commissioner; and

2.25 (8) any reason for which an individual or entity could be excluded from participation in
2.26 the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act.

2.27 (b) For the purposes of this section, goods or services for which payment is made from
2.28 medical assistance includes but is not limited to care and services identified in section
2.29 256B.0625 or provided pursuant to any federally approved waiver.

2.30 (c) Regardless of the source of payment or other item of value, the commissioner may
2.31 impose sanctions against any individual or entity that solicits, receives, pays, or offers to

3.1 pay any illegal remuneration as described in section 142E.51, subdivision 6a, in violation
 3.2 of section 609.542, subdivision 2, or in violation of United States Code, title 42, section
 3.3 1320a-7b(b)(1) or (2). No conviction is required before the commissioner can impose
 3.4 sanctions under this paragraph.

3.5 (d) The commissioner may impose sanctions against a pharmacy provider for failure to
 3.6 respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph
 3.7 (g).

3.8 (e) The commissioner may impose sanctions against a pharmacy provider for failure to
 3.9 respond to a Minnesota drug acquisition cost survey under section 256B.0625, subdivision
 3.10 13e, paragraph (i).

3.11 (f) For the purposes of this section, "abuse" means the activities listed in paragraph (a),
 3.12 clauses (2), (3), and (7), but does not include billing errors that result in unintended
 3.13 overcharges.

3.14 Sec. 4. Minnesota Statutes 2024, section 256B.064, subdivision 1b, is amended to read:

3.15 Subd. 1b. **Sanctions available.** (a) The commissioner may impose the following sanctions
 3.16 for the conduct described in subdivision 1a: ~~suspension or withholding of~~ suspending
 3.17 payments to an individual or entity and; withholding payments to an individual or entity;
 3.18 suspending or terminating participation in the program; terminating participation in the
 3.19 program; or imposition of imposing a fine under subdivision 2, paragraph (g) 2a.

3.20 (b) When imposing sanctions under this section subdivision, the commissioner shall
 3.21 must consider the nature, chronicity, or severity of the conduct and the effect of the conduct
 3.22 on the health and safety of persons served by the individual or entity.

3.23 (c) The commissioner ~~shall~~ must suspend an individual's or entity's participation in the
 3.24 program for a minimum of five years if the individual or entity is convicted of a crime,
 3.25 received a stay of adjudication, or entered a court-ordered diversion program for an offense
 3.26 related to a provision of a health service under medical assistance, including a federally
 3.27 approved waiver, or health care fraud.

3.28 (d) Regardless of imposition of sanctions, the commissioner may make a referral to the
 3.29 appropriate state licensing board.

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

4.1 Sec. 5. Minnesota Statutes 2024, section 256B.064, subdivision 1d, is amended to read:

4.2 Subd. 1d. **Investigative costs.** (a) The commissioner may seek recovery of investigative
 4.3 costs from any individual or entity that willfully submits a claim for reimbursement for
 4.4 services that the individual or entity knows, or reasonably should have known, is a false
 4.5 representation and that results in the payment of public funds for which the individual or
 4.6 entity is ineligible.

4.7 (b) Billing errors that result in unintentional overcharges ~~shall~~ are not be grounds for
 4.8 investigative cost recoupment.

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

4.10 Sec. 6. Minnesota Statutes 2024, section 256B.064, subdivision 2, is amended to read:

4.11 Subd. 2. **Imposition of monetary recovery and sanctions; generally.** (a) The
 4.12 commissioner ~~shall~~ must determine any monetary amounts to be recovered and sanctions
 4.13 to be imposed upon an individual or entity under this section. Except as provided in
 4.14 ~~paragraphs (b) and (d), neither~~ subdivisions 2b to 2d, the commissioner must not obtain a
 4.15 monetary recovery nor or impose a sanction ~~will be imposed by the commissioner~~ without
 4.16 prior notice and an opportunity for a hearing, according to chapter 14, on the commissioner's
 4.17 proposed action, ~~provided that the commissioner may suspend or reduce payment to an~~
 4.18 ~~individual or entity, except a nursing home or convalescent care facility, after notice and~~
 4.19 ~~prior to the hearing if in the commissioner's opinion that action is necessary to protect the~~
 4.20 ~~public welfare and the interests of the program.~~

4.21 ~~(b) Except when the commissioner finds good cause not to suspend payments under~~
 4.22 ~~Code of Federal Regulations, title 42, section 455.23(e) or (f), the commissioner shall~~
 4.23 ~~withhold or reduce payments to an individual or entity without providing advance notice~~
 4.24 ~~of such withholding or reduction if either of the following occurs:~~

4.25 ~~(1) the individual or entity is convicted of a crime involving the conduct described in~~
 4.26 ~~subdivision 1a; or~~

4.27 ~~(2) the commissioner determines there is a credible allegation of fraud for which an~~
 4.28 ~~investigation is pending under the program. Allegations are considered credible when they~~
 4.29 ~~have an indicium of reliability and the state agency has reviewed all allegations, facts, and~~
 4.30 ~~evidence carefully and acts judiciously on a case-by-case basis. A credible allegation of~~
 4.31 ~~fraud is an allegation which has been verified by the state, from any source, including but~~
 4.32 ~~not limited to:~~

4.33 ~~(i) fraud hotline complaints;~~

5.1 ~~(ii) claims data mining; and~~

5.2 ~~(iii) patterns identified through provider audits, civil false claims cases, and law~~
5.3 ~~enforcement investigations.~~

5.4 ~~(c) The commissioner must send notice of the withholding or reduction of payments~~
5.5 ~~under paragraph (b) within five days of taking such action unless requested in writing by a~~
5.6 ~~law enforcement agency to temporarily withhold the notice. The notice must:~~

5.7 ~~(1) state that payments are being withheld according to paragraph (b);~~

5.8 ~~(2) set forth the general allegations as to the nature of the withholding action, but need~~
5.9 ~~not disclose any specific information concerning an ongoing investigation;~~

5.10 ~~(3) except in the case of a conviction for conduct described in subdivision 1a, state that~~
5.11 ~~the withholding is for a temporary period and cite the circumstances under which withholding~~
5.12 ~~will be terminated;~~

5.13 ~~(4) identify the types of claims to which the withholding applies; and~~

5.14 ~~(5) inform the individual or entity of the right to submit written evidence for consideration~~
5.15 ~~by the commissioner.~~

5.16 ~~(d) The withholding or reduction of payments will not continue after the commissioner~~
5.17 ~~determines there is insufficient evidence of fraud by the individual or entity, or after legal~~
5.18 ~~proceedings relating to the alleged fraud are completed, unless the commissioner has sent~~
5.19 ~~notice of intention to impose monetary recovery or sanctions under paragraph (a). Upon~~
5.20 ~~conviction for a crime related to the provision, management, or administration of a health~~
5.21 ~~service under medical assistance, a payment held pursuant to this section by the commissioner~~
5.22 ~~or a managed care organization that contracts with the commissioner under section 256B.035~~
5.23 ~~is forfeited to the commissioner or managed care organization, regardless of the amount~~
5.24 ~~charged in the criminal complaint or the amount of criminal restitution ordered.~~

5.25 ~~(e) The commissioner shall suspend or terminate an individual's or entity's participation~~
5.26 ~~in the program without providing advance notice and an opportunity for a hearing when the~~
5.27 ~~suspension or termination is required because of the individual's or entity's exclusion from~~
5.28 ~~participation in Medicare. Within five days of taking such action, the commissioner must~~
5.29 ~~send notice of the suspension or termination. The notice must:~~

5.30 ~~(1) state that suspension or termination is the result of the individual's or entity's exclusion~~
5.31 ~~from Medicare;~~

5.32 ~~(2) identify the effective date of the suspension or termination; and~~

6.1 ~~(3) inform the individual or entity of the need to be reinstated to Medicare before~~
 6.2 ~~reapplying for participation in the program.~~

6.3 ~~(f)~~ (b) Upon receipt of a notice under paragraph (a) or subdivision 2c or 2d that a
 6.4 monetary recovery or sanction is to be or has been imposed, an individual or entity may
 6.5 request a contested case, as defined in section 14.02, subdivision 3, by filing with the
 6.6 commissioner a written request of appeal. The appeal request must be received by the
 6.7 commissioner no later than 30 days after the date the notification of monetary recovery or
 6.8 sanction was mailed to the individual or entity. The appeal request must specify:

6.9 (1) each disputed item, the reason for the dispute, and an estimate of the dollar amount
 6.10 involved for each disputed item;

6.11 (2) the computation that the individual or entity believes is correct;

6.12 (3) the authority in statute or rule upon which the individual or entity relies for each
 6.13 disputed item;

6.14 (4) the name and address of the person or entity with whom contacts may be made
 6.15 regarding the appeal; and

6.16 (5) other information required by the commissioner.

6.17 ~~(g) The commissioner may order an individual or entity to forfeit a fine for failure to~~
 6.18 ~~fully document services according to standards in this chapter and Minnesota Rules, chapter~~
 6.19 ~~9505. The commissioner may assess fines if specific required components of documentation~~
 6.20 ~~are missing. The fine for incomplete documentation shall equal 20 percent of the amount~~
 6.21 ~~paid on the claims for reimbursement submitted by the individual or entity, or up to \$5,000,~~
 6.22 ~~whichever is less. If the commissioner determines that an individual or entity repeatedly~~
 6.23 ~~violated this chapter, chapter 254B or 245G, or Minnesota Rules, chapter 9505, related to~~
 6.24 ~~the provision of services to program recipients and the submission of claims for payment,~~
 6.25 ~~the commissioner may order an individual or entity to forfeit a fine based on the nature,~~
 6.26 ~~severity, and chronicity of the violations, in an amount of up to \$5,000 or 20 percent of the~~
 6.27 ~~value of the claims, whichever is greater.~~

6.28 ~~(h) The individual or entity shall pay the fine assessed on or before the payment date~~
 6.29 ~~specified. If the individual or entity fails to pay the fine, the commissioner may withhold~~
 6.30 ~~or reduce payments and recover the amount of the fine. A timely appeal shall stay payment~~
 6.31 ~~of the fine until the commissioner issues a final order.~~

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

7.1 Sec. 7. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
7.2 to read:

7.3 Subd. 2a. **Imposition of fines.** (a) The commissioner may order an individual or entity
7.4 to forfeit a fine for failure to fully document services according to standards in this chapter
7.5 and Minnesota Rules, chapter 9505. The commissioner may assess fines if specific required
7.6 components of documentation are missing. The fine for incomplete documentation equals
7.7 20 percent of the amount paid on the claims for reimbursement submitted by the individual
7.8 or entity, or up to \$5,000, whichever is less. If the commissioner determines that an individual
7.9 or entity repeatedly violated this chapter, chapter 245G or 254B, or Minnesota Rules, chapter
7.10 9505, related to the provision of services to program recipients and the submission of claims
7.11 for payment, the commissioner may order an individual or entity to forfeit a fine based on
7.12 the nature, severity, and chronicity of the violations, in an amount of up to \$5,000 or 20
7.13 percent of the value of the claims, whichever is greater.

7.14 (b) The individual or entity must pay the fine assessed on or before the payment date
7.15 specified by the commissioner. If the individual or entity fails to pay the fine, the
7.16 commissioner may withhold or reduce payments and recover the amount of the fine. A
7.17 timely appeal stays payment of the fine until the commissioner issues a final order.

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

7.19 Sec. 8. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
7.20 to read:

7.21 Subd. 2b. **Mandatory suspension or termination after exclusion from participation**
7.22 **in Medicare.** (a) The commissioner must suspend or terminate an individual's or entity's
7.23 participation in the program without providing advance notice and an opportunity for a
7.24 hearing when the suspension or termination is required because of the individual's or entity's
7.25 exclusion from participation in Medicare.

7.26 (b) Within five days of taking an action under paragraph (a), the commissioner must
7.27 send notice of the suspension or termination. The notice must:

7.28 (1) state that the suspension or termination is the result of the individual's or entity's
7.29 exclusion from Medicare;

7.30 (2) identify the effective date of the suspension or termination; and

7.31 (3) inform the individual or entity of the need to be reinstated to Medicare before
7.32 reapplying for participation in the program.

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

8.2 Sec. 9. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
8.3 to read:

8.4 Subd. 2c. **Imposition of monetary recovery and sanctions before a hearing.** (a) Except
8.5 as provided in paragraph (b), the commissioner may withhold or reduce payment to an
8.6 individual or entity after notice but before a hearing if, in the commissioner's opinion,
8.7 withholding or reducing payment is necessary to protect the public welfare and the interests
8.8 of the program.

8.9 (b) Notwithstanding subdivision 2d, unless the commissioner first complies with the
8.10 applicable requirements of paragraph (c), the commissioner must not withhold or reduce
8.11 payments to the following entities:

8.12 (1) a nursing home;

8.13 (2) a convalescing care facility;

8.14 (3) an entity providing residential supports and services as described in section 245D.03,
8.15 subdivision 1, paragraph (c), clause (3); or

8.16 (4) an entity providing integrated community services described in section 245D.03,
8.17 subdivision 1, paragraph (c), clause (8).

8.18 (c) When withholding or reducing payments under paragraph (a) or subdivision 2d to
8.19 an entity listed in paragraph (b), the commissioner must confirm suitable alternative services
8.20 and housing are established for the affected recipient before withholding or reducing
8.21 payments if withholding or reducing payments puts a recipient of the goods or services
8.22 provided by the entity in imminent danger of harm or at risk of homelessness.

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

8.24 Sec. 10. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
8.25 to read:

8.26 Subd. 2d. **Imposition of monetary recovery and sanctions without prior notice.** (a)
8.27 Except as provided in subdivision 2c, when law enforcement requests that the commissioner
8.28 not suspend payments, or when the commissioner finds good cause not to suspend payments
8.29 under Code of Federal Regulations, title 42, section 455.23(e) or (f), the commissioner must
8.30 withhold or reduce payments to an individual or entity without providing advance notice
8.31 of the withholding or reduction if either of the following occurs:

9.1 (1) the individual or entity is convicted of a crime involving the conduct described in
9.2 subdivision 1a; or

9.3 (2) the commissioner determines there is a credible allegation of fraud for which an
9.4 investigation is pending under the program. Allegations are considered credible when they
9.5 are supported by a preponderance of the evidence and the state agency has reviewed and
9.6 verified all allegations, facts, and evidence carefully and acts judiciously on a case-by-case
9.7 basis. A credible allegation of abuse is not a credible allegation of fraud.

9.8 (b) If the commissioner withholds or reduces payments under paragraph (a), clause (2),
9.9 the commissioner may withhold payments only for the specific submitted claims that the
9.10 commissioner has determined are potentially fraudulent and referred to law enforcement,
9.11 unless the commissioner determines that the credible allegation of fraud is an allegation of
9.12 pervasive fraud.

9.13 (c) For purposes of this subdivision, "fraud" means presenting information that is false
9.14 in whole or in part to the commissioner with the intent of obtaining greater compensation
9.15 for the provision of a good or service available under this chapter than the vendor of the
9.16 good or service is legally entitled.

9.17 (d) The commissioner may consider an allegation of fraud from any source, including
9.18 but not limited to:

9.19 (1) fraud hotline complaints;

9.20 (2) claims data mining;

9.21 (3) patterns identified through provider audits, civil false claims cases, law enforcement
9.22 investigations, and investigations by other state or federal agencies; and

9.23 (4) court filings or other legal documents.

9.24 (e) The commissioner must send notice of the withholding or reduction of payments
9.25 under paragraph (a) within five days of withholding or reducing payment unless requested
9.26 in writing by a law enforcement agency to temporarily withhold the notice. The notice need
9.27 not disclose specific information concerning an ongoing investigation. The notice must:

9.28 (1) state that payments are being withheld according to paragraph (a);

9.29 (2) set forth the allegations as to the nature of the withholding action, which must specify:

9.30 (i) each disputed item, and for each disputed item the reason for the dispute and an
9.31 estimate of the dollar amount involved;

9.32 (ii) the computation that the commissioner believes is correct;

- 10.1 (iii) the statute or rule the commissioner believes the individual or entity violated; and
- 10.2 (iv) other information necessary to aid the individual or entity when providing written
- 10.3 evidence under clause (5) or filing an appeal under section 256B.064, subdivision 2;
- 10.4 (3) except in the case of a conviction for conduct described in subdivision 1a, state that
- 10.5 the withholding is for a temporary period not to exceed 60 days and cite the circumstances
- 10.6 under which withholding will be terminated;
- 10.7 (4) identify the types of claims to which the withholding applies; and
- 10.8 (5) inform the individual or entity of the right to submit written evidence for consideration
- 10.9 by the commissioner.
- 10.10 (f) The commissioner must acknowledge receipt of any written evidence submitted by
- 10.11 the individual or entity within five days of receipt of the written evidence. Within five days
- 10.12 of the commissioner's acknowledgment of receipt, the commissioner must (1) cease to
- 10.13 withhold or reduce payments, or (2) respond to the individual or entity with an explanation
- 10.14 of the commissioner's continued determination that there is sufficient evidence of fraud to
- 10.15 continue withholding or reducing payments.
- 10.16 (g) The commissioner must cease to withhold or reduce payments under this subdivision
- 10.17 after 60 days have passed, after the commissioner determines there is insufficient evidence
- 10.18 of fraud by the individual or entity, or after legal proceedings relating to the alleged fraud
- 10.19 are completed, unless the commissioner has sent notice of intention to impose monetary
- 10.20 recovery or sanctions.
- 10.21 Sec. 11. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
- 10.22 to read:
- 10.23 Subd. 2e. **Forfeiture of withheld payments upon criminal conviction.** Upon conviction
- 10.24 for a crime related to the provision, management, or administration of a health service under
- 10.25 medical assistance, a payment held pursuant to this section by the commissioner or a managed
- 10.26 care organization that contracts with the commissioner under section 256B.035 is forfeited
- 10.27 to the commissioner or managed care organization, regardless of the amount charged in the
- 10.28 criminal complaint or the amount of criminal restitution ordered.
- 10.29 **EFFECTIVE DATE.** This section is effective the day following final enactment.

11.1 Sec. 12. Minnesota Statutes 2024, section 256B.064, subdivision 3, is amended to read:

11.2 Subd. 3. **Mandates on prohibited payments.** (a) The commissioner ~~shall~~ must maintain
 11.3 and publish a list of each excluded individual and entity that was convicted of a crime related
 11.4 to the provision, management, or administration of a medical assistance health service, or
 11.5 suspended or terminated under subdivision ~~2~~ 2b. Medical assistance payments cannot be
 11.6 made by an individual or entity for items or services furnished either directly or indirectly
 11.7 by an excluded individual or entity, or at the direction of excluded individuals or entities.

11.8 (b) The entity must check the exclusion list on a monthly basis and document the date
 11.9 and time the exclusion list was checked and the name and title of the person who checked
 11.10 the exclusion list. The entity must immediately terminate payments to an individual or entity
 11.11 on the exclusion list.

11.12 (c) An entity's requirement to check the exclusion list and to terminate payments to
 11.13 individuals or entities on the exclusion list applies to each individual or entity on the
 11.14 exclusion list, even if the named individual or entity is not responsible for direct patient
 11.15 care or direct submission of a claim to medical assistance.

11.16 (d) An entity that pays medical assistance program funds to an individual or entity on
 11.17 the exclusion list must refund any payment related to either items or services rendered by
 11.18 an individual or entity on the exclusion list from the date the individual or entity is first paid
 11.19 or the date the individual or entity is placed on the exclusion list, whichever is later, and an
 11.20 entity may be subject to:

11.21 (1) sanctions under ~~subdivision 2~~ this section;

11.22 (2) a civil monetary penalty of up to \$25,000 for each determination by the department
 11.23 that the vendor employed or contracted with an individual or entity on the exclusion list;
 11.24 and

11.25 (3) other fines or penalties allowed by law.

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

11.27 Sec. 13. Minnesota Statutes 2024, section 256B.064, subdivision 4, is amended to read:

11.28 Subd. 4. **Notice.** (a) The department ~~shall~~ must serve the notice required under ~~subdivision~~
 11.29 subdivisions 2 and 2d using a signature-verified confirmed delivery method to the address
 11.30 submitted to the department by the individual or entity. Service is complete upon mailing.

11.31 (b) The department ~~shall~~ must give notice in writing to a recipient placed in the Minnesota
 11.32 restricted recipient program under section 256B.0646 and Minnesota Rules, part 9505.2200.

12.1 The department ~~shall~~ must send the notice by first class mail to the recipient's current address
 12.2 on file with the department. A recipient placed in the Minnesota restricted recipient program
 12.3 may contest the placement by submitting a written request for a hearing to the department
 12.4 within 90 days of the notice being mailed.

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

12.6 Sec. 14. Minnesota Statutes 2024, section 256B.064, subdivision 5, is amended to read:

12.7 Subd. 5. **Immunity; good faith reporters.** (a) A person who makes a good faith report
 12.8 is immune from any civil or criminal liability that might otherwise arise from reporting or
 12.9 participating in the investigation. Nothing in this subdivision affects an individual's or
 12.10 entity's responsibility for an overpayment established under this subdivision.

12.11 (b) A person employed by a lead investigative agency who is conducting or supervising
 12.12 an investigation or enforcing the law according to the applicable law or rule is immune from
 12.13 any civil or criminal liability that might otherwise arise from the person's actions, if the
 12.14 person is acting in good faith and exercising due care.

12.15 (c) For purposes of this subdivision, "person" includes a natural person or any form of
 12.16 a business or legal entity.

12.17 (d) After an investigation is complete, the reporter's name must be kept confidential.
 12.18 The subject of the report may compel disclosure of the reporter's name only with the consent
 12.19 of the reporter or upon a written finding by a district court that the report was false and there
 12.20 is evidence that the report was made in bad faith. This subdivision does not alter disclosure
 12.21 responsibilities or obligations under the Rules of Criminal Procedure, except that when the
 12.22 identity of the reporter is relevant to a criminal prosecution the district court ~~shall~~ must
 12.23 conduct an in-camera review before determining whether to order disclosure of the reporter's
 12.24 identity.

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

12.26 Sec. 15. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; MEDICAL**
 12.27 **ASSISTANCE PROGRAM INTEGRITY ADVISORY BOARD.**

12.28 (a) By January 1, 2027, the commissioner of human services must establish a medical
 12.29 assistance program integrity advisory board. The board must oversee medical assistance
 12.30 program integrity efforts, evaluate the efforts, and provide recommendations, including but
 12.31 not limited to legislative changes, to the commissioner on ways to improve medical assistance

13.1 program integrity. The board must advise the commissioner on enforcement proportionality,
 13.2 analytics governance, and program integrity metrics.

13.3 (b) The board must consist of seven members appointed by the commissioner of human
 13.4 services and must include:

13.5 (1) at least one member who is a forensic accountant;

13.6 (2) at least one member who is a data scientist;

13.7 (3) at least one member who is a long-term services and supports program expert;

13.8 (4) at least one member who is a program design and evaluation specialist; and

13.9 (5) at least one member of the public.

13.10 (c) The commissioner must annually select a board chair from among the members. The
 13.11 commissioner must develop procedures for appointing new members, compensation for
 13.12 members, and term length, if any, for members.

13.13 **Sec. 16. DIRECTION TO COMMISSIONER OF HUMAN SERVICES; MEDICAL**
 13.14 **ASSISTANCE PROVIDER ENROLLMENT STANDARDS.**

13.15 (a) By January 1, 2027, the commissioner of human services must make recommendations
 13.16 to the chairs and ranking minority members of the legislative committees with jurisdiction
 13.17 over human services policy and finance regarding statutory and program changes to ensure
 13.18 only qualified, prepared, and financially stable providers are permitted to enroll as a medical
 13.19 assistance provider type designated by the commissioner as high-risk under Minnesota
 13.20 Statutes, section 256B.04, subdivision 21.

13.21 (b) The commissioner must include in the recommendations enhanced provider enrollment
 13.22 screening standards related to the provider's regulatory knowledge, operational readiness,
 13.23 internal controls, financial liquidity and solvency, and capacity to comply with state and
 13.24 federal Medicaid requirements.

13.25 (c) In developing the recommendations, the commissioner must consult with the Health
 13.26 Law Section of the Minnesota State Bar Association, representatives of the medical assistance
 13.27 providers subject to the recommendations being considered, and other impacted groups.

13.28 **Sec. 17. DIRECTION TO COMMISSIONER OF HUMAN SERVICES; PROGRAM**
 13.29 **INTEGRITY TECHNOLOGY MODERNIZATION.**

13.30 By January 1, 2027, the commissioner of human services must develop recommendations
 13.31 on how to modernize program integrity infrastructure within the Department of Human

14.1 Services. The recommendations must include the infrastructure's capability to provide
 14.2 near-real-time analytics and risk scoring; prepayment review and anomaly detection;
 14.3 cross-matching of enrollment data, licensure data, and claims data; and security dashboards
 14.4 for audits and investigations with privacy safeguards. By January 15, 2027, the commissioner
 14.5 must provide recommendations to the chairs and ranking minority members of the legislative
 14.6 committees with jurisdiction over human services program integrity functions.

14.7 **Sec. 18. DIRECTION TO COMMISSIONER OF HUMAN SERVICES; PROGRAM**
 14.8 **STRUCTURE AND DESIGN AUDITS.**

14.9 (a) By August 1, 2026, the commissioner of human services must select and contract
 14.10 with an independent research entity to conduct comprehensive program structure and design
 14.11 audits on the services listed in paragraph (b). Each audit must identify structural incentive
 14.12 misalignments; undue compliance burdens on good-faith providers; regulatory and billing
 14.13 ambiguities; and gaps in utilization controls. Each audit must also provide evidence-based
 14.14 redesign recommendations.

14.15 (b) The services that must be audited by the independent research entity include:

14.16 (1) adult companion services;

14.17 (2) adult day services;

14.18 (3) adult rehabilitative mental health services;

14.19 (4) assertive community treatment;

14.20 (5) community first services and supports;

14.21 (6) early intensive developmental and behavioral intervention;

14.22 (7) individualized home supports;

14.23 (8) integrated community supports;

14.24 (9) intensive residential treatment services;

14.25 (10) night supervision services;

14.26 (11) nonemergency medical transportation services;

14.27 (12) peer recovery support services; and

14.28 (13) recuperative care.

14.29 (c) Each audit must be completed by January 1, 2027. The commissioner must submit
 14.30 each completed audit report within 30 days of receipt to the chairs and ranking minority

15.1 members of the legislative committees with jurisdiction over human services program
15.2 integrity functions.

15.3 **Sec. 19. DIRECTION TO COMMISSIONER OF HUMAN SERVICES;**
15.4 **PROPORTIONAL MEDICAL ASSISTANCE PROGRAM INTEGRITY**
15.5 **INTERVENTIONS.**

15.6 (a) By January 1, 2027, the commissioner of human services must make recommendations
15.7 to the chairs and ranking minority members of the legislative committees with jurisdiction
15.8 over human services policy and finance on modernizing medical assistance program integrity
15.9 efforts to strengthen fraud deterrence and promote clarity, proportionality based on the
15.10 severity of an infraction, provider education, client protection, and continuity of care.

15.11 (b) The commissioner must include in the recommendations a comprehensive approach
15.12 to proportional medical assistance program integrity interventions commensurate with the
15.13 severity of an infraction of a medical assistance program requirement.

15.14 (c) For the purposes of the recommendations, the commissioner must consider three
15.15 levels of severity:

15.16 (1) low-severity conduct, which includes clerical or documentation deficiencies with no
15.17 evidence of intent to defraud;

15.18 (2) moderate-severity conduct, which includes repeat errors, evidence of weak internal
15.19 controls, or other behavior that results in a pattern of improper payment; and

15.20 (3) high-severity conduct, which includes intentional actions by a provider to defraud
15.21 and gain unearned payment.

15.22 (d) For the purposes of the recommendations, the commissioner must consider three
15.23 levels of intervention:

15.24 (1) provider education for low-severity conduct;

15.25 (2) targeted audits for moderate-severity conduct; and

15.26 (3) suspended provider enrollment for high-severity conduct.

15.27 (e) In developing the recommendations, the commissioner must consult with the Health
15.28 Law Section of the Minnesota State Bar Association, representatives of the medical assistance
15.29 providers subject to the recommendations being considered, and other impacted groups.

16.1 Sec. 20. APPROPRIATION; MINNESOTA ATTORNEY GENERAL.

16.2 \$391,000 in fiscal year 2027 is appropriated from the general fund to the attorney general
 16.3 to increase the number of staff within the Medicaid Fraud Control Unit to improve program
 16.4 integrity and increase the Medical Fraud Control Unit's capacity for compliance efforts.

16.5 **ARTICLE 2**

16.6 **MEDICAL ASSISTANCE PROVIDER ENROLLMENT MODIFICATIONS**

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

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

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

16.13 (2) the individual designated as the authorized agent under section 142B.10, subdivision
 16.14 1, paragraph (b);

16.15 (3) the individual designated as the compliance officer under section ~~256B.04, subdivision~~
 16.16 ~~21, paragraph (g)~~ 256B.044, subdivision 8, paragraph (b);

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

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

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

16.22 (b) Controlling individual does not include:

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

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

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

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

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

17.5 (4) an individual who is a member of an organization exempt from taxation under section
17.6 290.05, unless the individual is also an officer, owner, or managerial official of the program
17.7 or owns any of the beneficial interests not excluded in this subdivision. This clause does
17.8 not exclude from the definition of controlling individual an organization that is exempt from
17.9 taxation; or

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

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

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

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

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

17.24 (2) the individual designated as the authorized agent under section 245A.04, subdivision
17.25 1, paragraph (b);

17.26 (3) the individual designated as the compliance officer under section ~~256B.04, subdivision~~
17.27 ~~21, paragraph (g)~~ 256B.044, subdivision 8, paragraph (b);

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

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

17.31 (b) Controlling individual does not include:

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

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

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

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

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

18.13 (4) an individual who is a member of an organization exempt from taxation under section
 18.14 290.05, unless the individual is also an officer, owner, or managerial official of the program
 18.15 or owns any of the beneficial interests not excluded in this subdivision. This clause does
 18.16 not exclude from the definition of controlling individual an organization that is exempt from
 18.17 taxation; or

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

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

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

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

18.31 (1) maintaining a current understanding of the licensing requirements sufficient to ensure
 18.32 compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph

19.1 (e), and when applicable, as identified in section ~~256B.04, subdivision 21, paragraph (g)~~
19.2 256B.044, subdivision 8;

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

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

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

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

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

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

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

19.25 Sec. 4. Minnesota Statutes 2024, section 256B.04, subdivision 5, is amended to read:

19.26 Subd. 5. **Annual report required.** The state agency within 60 days after the close of
19.27 each fiscal year, shall prepare and print for the fiscal year a report that includes: a full
19.28 account of the operations and expenditure of funds under this chapter; a full account of the
19.29 activities undertaken in accordance with subdivision 10; adequate and complete statistics
19.30 divided by counties about all medical assistance provided in accordance with this chapter;
19.31 a full account of all pre-enrollment, postenrollment, and unannounced site visits to providers
19.32 under section 256B.044, subdivision 5; and any other information it may deem advisable.

20.1 Sec. 5. Minnesota Statutes 2025 Supplement, section 256B.04, subdivision 21, is amended
20.2 to read:

20.3 Subd. 21. **Provider enrollment.** ~~(a)~~ The commissioner shall enroll providers and conduct
20.4 screening activities as required by Code of Federal Regulations, title 42, section 455, subpart
20.5 E, and sections 256B.044 to 256B.0445.

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

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

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

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

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

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

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

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

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

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

20.31 ~~(d) If a provider fails to comply with any individual provider requirement or condition~~
20.32 ~~of participation, the commissioner may suspend the provider's ability to bill until the provider~~

21.1 ~~comes into compliance. The commissioner's decision to suspend the provider is not subject~~
21.2 ~~to an administrative appeal.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22.20 ~~(j) As a condition of enrollment in medical assistance, the commissioner shall require~~
22.21 ~~that a provider designated "moderate" or "high-risk" by the Centers for Medicare and~~
22.22 ~~Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid~~
22.23 ~~Services, its agents, or its designated contractors and the state agency, its agents, or its~~
22.24 ~~designated contractors to conduct unannounced on-site inspections of any provider location.~~
22.25 ~~The commissioner shall publish in the Minnesota Health Care Program Provider Manual a~~
22.26 ~~list of provider types designated "limited," "moderate," or "high-risk," based on the criteria~~
22.27 ~~and standards used to designate Medicare providers in Code of Federal Regulations, title~~
22.28 ~~42, section 424.518. The list and criteria are not subject to the requirements of chapter 14.~~
22.29 ~~The commissioner's designations are not subject to administrative appeal.~~

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

23.1 ~~commissioner or the Centers for Medicare and Medicaid Services that a provider is designated~~
23.2 ~~high-risk for fraud, waste, or abuse.~~

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

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

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

23.26 ~~(m) The Department of Human Services may require a provider to purchase a surety~~
23.27 ~~bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment~~
23.28 ~~if: (1) the provider fails to demonstrate financial viability, (2) the department determines~~
23.29 ~~there is significant evidence of or potential for fraud and abuse by the provider, or (3) the~~
23.30 ~~provider or category of providers is designated high-risk pursuant to paragraph (f) and as~~
23.31 ~~per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in an~~
23.32 ~~amount of \$100,000 or ten percent of the provider's payments from Medicaid during the~~
23.33 ~~immediately preceding 12 months, whichever is greater. The surety bond must name the~~
23.34 ~~Department of Human Services as an obligee and must allow for recovery of costs and fees~~
23.35 ~~in pursuing a claim on the bond. This paragraph does not apply if the provider currently~~

24.1 ~~maintains a surety bond under the requirements in section 256B.051, 256B.0659, 256B.0701,~~
 24.2 ~~or 256B.85.~~

24.3 Sec. 6. **[256B.044] PROVIDER ENROLLMENT.**

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

24.9 (b) The list and criteria are not subject to the requirements of chapter 14, and section
 24.10 14.386 does not apply.

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

24.12 Subd. 2. Required verifications and checks. The commissioner must perform the
 24.13 following verifications and checks prior to making an enrollment determination and
 24.14 periodically thereafter:

24.15 (1) verify that the provider meets applicable federal and state requirements for the
 24.16 provider type;

24.17 (2) conduct license verifications, as applicable, including verification of current licensure
 24.18 in Minnesota and in any other state in which the provider is or was previously licensed, in
 24.19 accordance with Code of Federal Regulations, title 42, section 455.412;

24.20 (3) conduct database checks on a pre-enrollment and postenrollment basis to ensure that
 24.21 the provider continues to meet the enrollment criteria for the provider type, in accordance
 24.22 with Code of Federal Regulations, title 42, section 455.436;

24.23 (4) confirm that the provider and any disclosed owners, managing employees, or
 24.24 controlling individuals are not excluded from participation in any state's Medicaid program,
 24.25 Medicare, or any other federal health care program;

24.26 (5) verify the provider's National Provider Identifier and, as applicable, Medicare
 24.27 enrollment status;

24.28 (6) verify the provider's tax identification number and business registration status;

24.29 (7) verify the provider's ownership and control disclosures as required under federal
 24.30 law; and

25.1 (8) conduct any additional screenings, verifications, or reviews that are necessary to
25.2 protect the integrity of the medical assistance program or that are required under federal
25.3 law.

25.4 Subd. 3. **Required background studies.** (a) The commissioner must conduct a
25.5 background study under chapter 245C, for a provider applying for enrollment. The
25.6 background study must include a review of databases in section 245C.08, subdivision 1,
25.7 paragraph (a), clauses (1) to (5), and any other databases required under federal law.

25.8 (b) The commissioner must conduct a background study under this subdivision for each
25.9 individual with an ownership or control interest in, or who is an officer, director, agent,
25.10 managing employee, or other person with operational or managerial control of the provider.

25.11 (c) Fingerprint-based studies are required when mandated by federal law or when a
25.12 provider is designated moderate-risk or high-risk under subdivision 1.

25.13 (d) The commissioner may conduct background studies postenrollment as necessary.

25.14 (e) A provider's failure to submit to the commissioner the information required for a
25.15 background study under this subdivision is grounds for denial or termination of enrollment
25.16 in medical assistance.

25.17 (f) A provider's enrollment must be denied or terminated if a provider or individual
25.18 subject to a background study under this subdivision is disqualified under chapter 245C or
25.19 is excluded from participating in any federal health care programs.

25.20 Subd. 4. **Service location enrollment.** (a) A provider must enroll each provider-controlled
25.21 location where direct services are provided. "Provider-controlled location" means a physical
25.22 site owned, leased, operated, or otherwise controlled by the provider.

25.23 (b) Providers must report all provider-controlled locations where direct services are
25.24 provided to the commissioner and obtain approval before billing for services provided at a
25.25 new location.

25.26 (c) Separate enrollment is not required for services provided in a recipient's home or
25.27 community setting, telehealth services delivered from an enrolled site, compliant mobile
25.28 services, or other federally permissible exemptions.

25.29 (d) A provider's failure to enroll each provider-controlled location where direct services
25.30 are provided is grounds for sanctions under section 256B.064.

25.31 Subd. 5. **Site visits.** (a) As a condition of enrollment in medical assistance, the
25.32 commissioner shall require that a provider permit the Centers for Medicare and Medicaid

26.1 Services (CMS), CMS's agents, or CMS's designated contractors and the Department of
26.2 Human Services (DHS), DHS's agents, or DHS's designated contractors to conduct
26.3 unannounced site visits of any of a provider's enrolled locations.

26.4 (b) At a minimum, the commissioner must conduct the following site visits at each of
26.5 a provider's enrolled locations:

26.6 (1) pre-enrollment site visits for providers designated as moderate-risk or high-risk under
26.7 subdivision 1;

26.8 (2) postenrollment site visits for providers designated as moderate-risk or high-risk under
26.9 subdivision 1; and

26.10 (3) unannounced site visits, as follows:

26.11 (i) prior to payment of the provider's first claim after enrollment, when required under
26.12 federal law or due to program integrity concerns;

26.13 (ii) within 12 months after the provider begins to bill claims; and

26.14 (iii) prior to revalidation under section 256B.0441, subdivision 3.

26.15 (c) The commissioner may conduct additional announced or unannounced site visits
26.16 when necessary to verify compliance with enrollment requirements or to protect program
26.17 integrity.

26.18 (d) A provider's failure to permit a required site visit is grounds for denial, suspension,
26.19 or termination of enrollment and may result in denial of claims or recoupment of payments.

26.20 Subd. 6. **Surety bonds.** (a) The commissioner must require a provider to purchase a
26.21 surety bond as a condition of initial enrollment, reenrollment, revalidation, reinstatement,
26.22 or continued enrollment if:

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

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

26.26 (3) the provider or category of providers is designated high-risk pursuant to subdivision
26.27 1.

26.28 (b) The surety bond must be in an amount of \$100,000 or ten percent of the provider's
26.29 payments from Medicaid during the immediately preceding 12 months, whichever is greater.
26.30 The surety bond must name DHS as an obligee and must allow for recovery of costs and
26.31 fees in pursuing a claim on the bond.

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

27.3 Subd. 7. **Financial capacity.** As a condition of enrolling in medical assistance, the
27.4 commissioner must require, in a form and manner prescribed by the commissioner, that a
27.5 provider demonstrate sufficient financial capacity to operate, repay improper payments,
27.6 and make payroll for 90 days.

27.7 Subd. 8. **Compliance programs.** (a) The commissioner may require, as a condition of
27.8 enrollment in medical assistance, that a provider in a particular industry, of a particular
27.9 provider type, or with a particular risk categorization under subdivision 1, establish and
27.10 maintain a compliance program consistent with federal program integrity guidance issued
27.11 by CMS or the United States Department of Health and Human Services Office of Inspector
27.12 General.

27.13 (b) If an enrolled provider is required by the commissioner or by federal or state law to
27.14 designate an individual as the provider's compliance officer, the provider must appoint an
27.15 individual responsible for implementing and overseeing the compliance program.

27.16 (c) At a minimum, the compliance program must include policies and procedures designed
27.17 to:

27.18 (1) ensure adherence to federal and state laws and program requirements governing
27.19 medical assistance and prevent the submission of improper claims;

27.20 (2) train employees, agents, contractors, and subcontractors, including billing personnel,
27.21 on applicable federal and state laws and program requirements;

27.22 (3) establish procedures for receiving, investigating, and responding to allegations of
27.23 improper conduct and for implementing corrective actions;

27.24 (4) use auditing, monitoring, or other evaluation techniques to assess ongoing compliance;

27.25 (5) promptly report to the commissioner any credible evidence of violations of federal
27.26 and state laws or regulations governing medical assistance; and

27.27 (6) report and return identified medical assistance overpayments within 60 days after
27.28 discovery or by the date any corresponding cost report is due, whichever is later, in
27.29 accordance with federal law.

27.30 Subd. 9. **Incomplete provider enrollment applications.** The commissioner must deny
27.31 a provider's incomplete enrollment application if a provider fails to respond to the
27.32 commissioner's request for additional information within 60 days of the request.

28.1 Subd. 10. **Correspondence and notification.** The commissioner must deliver
28.2 correspondence and notifications, including notifications of termination and other actions,
28.3 electronically to a provider's MN-ITS mailbox. This subdivision does not apply to
28.4 correspondences and notifications related to background studies.

28.5 Sec. 7. **[256B.0441] PROVIDER REVALIDATION.**

28.6 Subdivision 1. **Requirement.** The commissioner must revalidate each enrolled provider
28.7 according to this section.

28.8 Subd. 2. **Schedule.** (a) The commissioner shall revalidate:

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

28.10 (2) each personal care assistance agency, CFSS provider-agency, and CFSS financial
28.11 management services provider at least once every three years;

28.12 (3) each EIDBI agency at least once every three years; and

28.13 (4) each medical-assistance-only provider type the commissioner deems high-risk under
28.14 section 256B.044, subdivision 1, at least every three years.

28.15 (b) The commissioner must conduct revalidation of a provider more frequently when
28.16 required under federal law or when necessary to protect program integrity.

28.17 Subd. 3. **Procedures.** (a) The commissioner shall conduct revalidation as follows:

28.18 (1) provide 30-day notice to the provider of the provider's revalidation due date, including
28.19 instructions for revalidation, a list of materials the provider must submit, and a notice about
28.20 the unannounced site visit required under paragraph (b);

28.21 (2) if a provider fails to submit all required materials or satisfy the requirements of
28.22 paragraph (b) by the due date, notify the provider of the deficiency within 14 days after the
28.23 due date and allow the provider an additional 14 days from the notification date to comply;
28.24 and

28.25 (3) if a provider fails to remedy a deficiency within the additional 28-day time period,
28.26 give 15-day notice of termination and immediately suspend the provider's ability to bill.
28.27 The commissioner's decision to suspend the provider's ability to bill is not subject to an
28.28 administrative appeal.

28.29 (b) The commissioner must conduct unannounced site visits at each of a provider's
28.30 enrolled locations under section 256B.044, subdivision 4, no more than 30 days prior to the
28.31 provider's revalidation due date.

29.1 (c) A provider must demonstrate financial capacity, as described under section 256B.044,
29.2 subdivision 7, as a requirement of revalidation under this subdivision.

29.3 **Sec. 8. [256B.0442] PROVIDER ENROLLMENT SUSPENSIONS AND**
29.4 **TERMINATIONS.**

29.5 Subdivision 1. **Suspension of billing privileges.** (a) If a provider fails to comply with
29.6 any individual provider requirement or condition of participation, the commissioner must
29.7 suspend the provider's ability to bill until the provider comes into compliance.

29.8 (b) Notwithstanding any law to the contrary, the commissioner may immediately impose
29.9 a suspension under this subdivision when necessary to protect public funds or ensure program
29.10 integrity.

29.11 (c) A suspension under this subdivision does not limit the authority of the commissioner
29.12 to issue any other sanction authorized under federal or state law.

29.13 (d) The commissioner's decision to suspend a provider's ability to bill is not subject to
29.14 an administrative appeal.

29.15 Subd. 2. **Revocation for lack of documentation.** (a) The commissioner may revoke
29.16 the enrollment of an ordering or rendering provider for a period of not more than one year
29.17 if the provider fails to maintain and, upon request from the commissioner, provide access
29.18 to documentation relating to written orders or requests for payment for durable medical
29.19 equipment, certifications for home health services, or referrals for other items or services
29.20 written or ordered by the provider when the commissioner has identified a pattern of a lack
29.21 of documentation. A pattern means a failure to maintain documentation or provide access
29.22 to documentation on more than one occasion.

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

29.25 Subd. 3. **Mandatory denial or termination of enrollment.** (a) The commissioner must
29.26 terminate or deny the enrollment of a provider when:

29.27 (1) an individual with a five percent or greater direct or indirect ownership interest in
29.28 the provider does not submit timely and accurate information and cooperate with the
29.29 screening methods required under section 256B.044;

29.30 (2) an individual with a five percent or greater direct or indirect ownership interest in
29.31 the provider has been convicted of a criminal offense related to the individual's involvement
29.32 in Medicare, Medicaid, or the Children's Health Insurance Program in the last ten years,

30.1 unless the commissioner determines that denial or termination of enrollment is not in the
30.2 best interests of the medical assistance program and the commissioner documents that
30.3 determination in writing;

30.4 (3) the provider or an individual was terminated from participation in Medicare on or
30.5 after January 1, 2011, or under a Medicaid program or Children's Health Insurance Program
30.6 of any other state, and is currently included in the termination database under Code of
30.7 Federal Regulations, title 42, section 455.417, except as provided in paragraph (b);

30.8 (4) the provider, or an individual with an ownership or control interest or who is an agent
30.9 or managing employee of the provider, fails to submit timely or accurate information, unless
30.10 the commissioner determines that termination or denial of enrollment is not in the best
30.11 interests of the medical assistance program and the commissioner documents that
30.12 determination in writing;

30.13 (5) the provider, or an individual with a five percent or greater direct or indirect ownership
30.14 interest in the provider, fails to submit sets of fingerprints in a form and manner determined
30.15 by the commissioner within 30 days of a request from CMS or the commissioner, unless
30.16 the commissioner determines that termination or denial of enrollment is not in the best
30.17 interests of the medical assistance program and the commissioner documents that
30.18 determination in writing;

30.19 (6) the provider fails to permit access to provider locations for any site visits under
30.20 section 256B.044, subdivision 5, unless the commissioner determines that termination or
30.21 denial of enrollment is not in the best interests of the medical assistance program and the
30.22 commissioner documents that determination in writing; or

30.23 (7) CMS or the commissioner determines that the provider has falsified any information
30.24 provided on the application or cannot verify the identity of any provider applicant.

30.25 (b) The commissioner may exempt a rehabilitation agency from termination or denial
30.26 that would otherwise be required under paragraph (a), clause (3), if the agency:

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

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

30.31 (3) serves primarily a pediatric population.

31.1 **Sec. 9. [256B.0443] PROVIDER PAYMENT WITHHOLDS.**

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

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

31.8 **Sec. 10. [256B.0444] ENROLLMENT MORATORIUM FOR HIGH-RISK**
 31.9 **PROVIDERS.**

31.10 Subdivision 1. **Provider enrollment moratorium.** (a) If the commissioner or the Centers
 31.11 for Medicare and Medicaid Services (CMS) designates a provider type as high-risk under
 31.12 section 256B.044, subdivision 1, the commissioner may issue a statewide or regional
 31.13 enrollment moratorium and stop accepting and processing applications from providers
 31.14 within that category within 30 days of the date of the designation or upon federal approval
 31.15 of the moratorium, whichever is later. A moratorium issued under this section is effective
 31.16 for a period of up to 24 months from the date the moratorium is issued.

31.17 (b) Before ending the moratorium under this section, the commissioner must revalidate
 31.18 the enrollment of each provider within the affected category in accordance with the
 31.19 revalidation procedures under section 256B.0441, subdivision 2.

31.20 Subd. 2. **Continued enrollment of new clients.** Nothing in this section prohibits an
 31.21 enrolled provider subject to a moratorium under this section from enrolling new clients or
 31.22 beneficiaries during the period of the enrollment moratorium.

31.23 Subd. 3. **Notice.** At least ten days prior to issuing an enrollment moratorium under this
 31.24 section, the commissioner must notify enrolled providers within the affected category and
 31.25 the chairs and ranking minority members of the legislative committees with jurisdiction
 31.26 over health and human services about the actions the commissioner plans to take under this
 31.27 section. The notice must:

31.28 (1) include a list of provider types to which the moratorium applies;

31.29 (2) provide a general explanation for the basis of the high-risk designation; and

31.30 (3) identify the start dates and anticipated durations of the enrollment moratorium.

31.31 Subd. 4. **Report to legislature.** Within 60 days of ending an enrollment moratorium
 31.32 under this section, the commissioner must submit a report to the chairs and ranking minority

32.1 members of the legislative committees with jurisdiction over health and human services.

32.2 The report must include, at a minimum:

32.3 (1) a summary of any sanctions imposed under section 256B.064 on any providers subject
 32.4 to the moratorium; and

32.5 (2) recommendations for modifying or terminating the provision of covered services
 32.6 delivered by provider types subject to the moratorium.

32.7 **Sec. 11. [256B.0445] ADDITIONAL PROVIDER ENROLLMENT REQUIREMENTS**
 32.8 **FOR SPECIFIC PROVIDER TYPES.**

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

32.14 (b) Upon initial enrollment, reenrollment, and notification of revalidation, all durable
 32.15 medical equipment, prosthetics, orthotics, and supplies medical suppliers meeting the durable
 32.16 medical equipment provider or supplier definition in paragraph (a), operating in Minnesota,
 32.17 and receiving Medicaid money must purchase a surety bond that is annually renewed,
 32.18 designates the state agency as the obligee, and is submitted in a form approved by the
 32.19 commissioner. For purposes of this paragraph, the following medical suppliers are not
 32.20 required to obtain a surety bond: a federally qualified health center, a home health agency,
 32.21 the Indian Health Service, a pharmacy, and a rural health clinic.

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

32.32 Subd. 2. **Providers licensed by the commissioner of human services.** An enrolled
 32.33 provider that is licensed by the commissioner under chapter 245A must designate an

33.1 individual as the licensee's compliance officer under section 256B.044, subdivision 8,
33.2 paragraph (b).

33.3 Subd. 3. **Providers licensed by the commissioner of health.** An enrolled provider that
33.4 is licensed by the commissioner of health as a home care provider under chapter 144A with
33.5 a home and community-based services designation under section 144A.484 on the home
33.6 care license, or as an assisted living facility under chapter 144G, must designate an individual
33.7 as the licensee's compliance officer under section 256B.044, subdivision 8, paragraph (b).

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

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

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

33.28 (c) For outpatient individual and group substance use disorder services under section
33.29 254B.0505, subdivision 1, clause (1), and adolescent treatment programs that are licensed
33.30 as outpatient treatment programs according to sections 245G.01 to 245G.18, provided on
33.31 or after January 1, 2021, payment rates must be increased by 20 percent over the rates in
33.32 effect on December 31, 2020.

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

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

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

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

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

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

34.24 (1) enroll as a medical assistance Minnesota health care program provider according to
34.25 Minnesota Rules, part 9505.0195, and ~~section 256B.04, subdivision 21~~ sections 256B.044
34.26 to 256B.0445, and meet all applicable provider standards and requirements;

34.27 (2) designate an individual as the agency's compliance officer who must perform the
34.28 duties described in section ~~256B.04, subdivision 21, paragraph (g)~~ 256B.044, subdivision
34.29 8, paragraph (b);

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

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

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

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

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

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

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

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

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

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

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

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

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

36.1 (16) provide required EIDBI intervention observation and direction at least once per
 36.2 month. Notwithstanding subdivision 13, paragraph (1), required EIDBI intervention
 36.3 observation and direction under this clause may be conducted via telehealth provided that
 36.4 no more than two consecutive monthly required EIDBI intervention observation and direction
 36.5 sessions under this clause are conducted via telehealth.

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

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

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

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

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

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

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

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

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

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

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

37.6 (b) The commissioner, in consultation with the Early Intensive Developmental and
37.7 Behavioral Intervention Advisory Council and stakeholders, must establish processes and
37.8 criteria for granting an exception under this paragraph. The commissioner may grant an
37.9 exception only if the exception would not compromise a person's safety and not diminish
37.10 the effectiveness of the treatment. The commissioner may establish an expiration date for
37.11 an exception granted under this paragraph. The commissioner may grant an exception for
37.12 the following:

37.13 (1) EIDBI provider qualifications under this section;

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

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

37.17 (c) If the commissioner, in consultation with the Early Intensive Developmental and
37.18 Behavioral Intervention Advisory Council and stakeholders, determines that a shortage no
37.19 longer exists, the commissioner must submit a notice that a shortage no longer exists to the
37.20 chairs and ranking minority members of the senate and the house of representatives
37.21 committees with jurisdiction over health and human services. The commissioner must post
37.22 the notice for public comment for 30 days. The commissioner shall consider public comments
37.23 before submitting to the legislature a request to end the shortage declaration. The
37.24 commissioner shall not declare the shortage of EIDBI providers ended without direction
37.25 from the legislature to declare it ended.

37.26 **Sec. 15. DIRECTION TO COMMISSIONER OF HUMAN SERVICES.**

37.27 The commissioner of human services must amend Minnesota Rules, part 9505.2165,
37.28 subpart 4, item C, to remove the citation to United States Code, title 42, section
37.29 1320a-7b(b)(3)(D), and insert a citation to United States Code, title 42, section 1320a-7b(b).
37.30 The commissioner may use the procedure under Minnesota Statutes, section 14.388,
37.31 subdivision 1, clause (3), for changes to Minnesota Rules pursuant to this section. Minnesota
37.32 Statutes, section 14.386, does not apply to rules adopted pursuant to this section except as
37.33 provided under Minnesota Statutes, section 14.388.

APPENDIX
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