

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	7871a	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, other human services programs, and programs administered

1.5 by the commissioner of children, youth, and families; 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; amending Minnesota Statutes

1.10 2024, sections 142A.03, by adding a subdivision; 142B.01, subdivision 8; 245.095,

1.11 by adding a subdivision; 245A.02, subdivision 5a; 245D.081, subdivision 3; 256.01,

1.12 by adding a subdivision; 256B.04, subdivision 5; 256B.064, subdivisions 1b, 1d,

1.13 2, 3, 4, 5, by adding subdivisions; 256B.073, subdivision 2; 256B.0949, subdivision

1.14 17; 256B.4912, subdivisions 12, 14, 15, by adding a subdivision; Minnesota Statutes

1.15 2025 Supplement, sections 15.013, by adding a subdivision; 245A.04, subdivisions

1.16 1, 7; 245A.05; 256B.04, subdivision 21; 256B.051, subdivision 6; 256B.064,

1.17 subdivision 1a; 256B.0701, subdivision 9; 256B.0759, subdivision 4; 256B.0949,

1.18 subdivision 16; 256B.4912, subdivision 1; proposing coding for new law in

1.19 Minnesota Statutes, chapters 142A; 256; 256B; repealing Minnesota Statutes 2025

1.20 Supplement, sections 256B.051, subdivision 6b; 256B.0701, subdivision 11.

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

1.22 **ARTICLE 1**

1.23 **PROGRAM INTEGRITY REQUIREMENTS**

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

1.25 subdivision to read:

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

1.27 administered by the commissioner of human services.

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

2.1 Sec. 2. Minnesota Statutes 2024, section 142A.03, is amended by adding a subdivision to
2.2 read:

2.3 Subd. 36. **Program integrity report.** Beginning November 30, 2026, and annually
2.4 thereafter, the commissioner must provide a report to the chairs and ranking minority
2.5 members of the legislative committees with jurisdiction over children, youth, and families
2.6 on program integrity functions within the Department of Children, Youth, and Families.

2.7 The report must include:

2.8 (1) an update from the Office of Inspector General at the Department of Children, Youth,
2.9 and Families with historical metrics and descriptive data, including the office's capacity to
2.10 meet licensing demands and data for the past five years on the number of maltreatment
2.11 reports and licensing complaints received, the results of maltreatment investigations, the
2.12 number of licenses issued for each provider type, the number of licensing investigations
2.13 and reviews completed, and the number of correction orders issued; and

2.14 (2) an update from the Office of Inspector General at the Department of Children, Youth,
2.15 and Families that generally includes caseload, site visit data, the number of child care
2.16 assistance program investigations and administrative reviews within the past five years,
2.17 recipient fraud investigation results involving multiple benefits from the past five years,
2.18 and updates on major fraud investigations.

2.19 Sec. 3. [142A.125] ELIGIBILITY TO RECEIVE PUBLIC MONEY; PRE-AWARD
2.20 RISK ASSESSMENT.

2.21 Subdivision 1. **Pre-award risk assessment; grant recipients.** (a) Prior to receiving a
2.22 grant award for a program administered by the commissioner, a potential grantee must
2.23 provide the commissioner with the applicable information specified under section 16B.981,
2.24 subdivision 2, for the most recent three-year period. This information must also include:

2.25 (1) the potential grantee's history of performing services during the most recent three-year
2.26 period that are substantially similar to the services the potential grantee is seeking to receive
2.27 public funds to provide; and

2.28 (2) for a potential grantee that is a for-profit business or nonprofit organization, evidence
2.29 of registration and good standing with the secretary of state for the most recent three-year
2.30 period, if applicable.

2.31 (b) For any information not submitted to the commissioner as required under this section
2.32 because the potential grantee determined it to be inapplicable, the potential grantee must

3.1 submit documentation noting each item that was not submitted and the reason why the
3.2 potential grantee determined it was inapplicable.

3.3 Subd. 2. **Pre-award risk assessment; licensure and reenrollment.** (a) Prior to renewing
3.4 a license or reenrolling in a program administered by the commissioner, a provider, vendor,
3.5 or individual must provide the commissioner with the applicable information specified
3.6 under section 16B.981, subdivision 2, for the most recent licensure or enrollment period.

3.7 (b) Notwithstanding paragraph (a), for a provider, vendor, or individual who has been
3.8 licensed or enrolled in a program administered by the commissioner for at least three years,
3.9 the provider, vendor, or individual must provide the commissioner with the applicable
3.10 information specified under section 16B.981, subdivision 2, for the most recent three-year
3.11 period.

3.12 (c) For any information not submitted to the commissioner as required under this section
3.13 because the provider, vendor, or individual determined it to be inapplicable, the provider,
3.14 vendor, or individual must submit documentation noting each item that was not submitted
3.15 and the reason why the provider, vendor, or individual determined it was inapplicable.

3.16 Subd. 3. **Commissioner duties.** (a) The commissioner must review all information
3.17 provided under subdivisions 1 and 2 prior to awarding a grant, renewing a license, or
3.18 reenrolling a provider. For any documentation submitted to the commissioner under
3.19 subdivision 1, paragraph (b), or subdivision 2, paragraph (c), the commissioner must review
3.20 and confirm that the determination of inapplicability made by the potential grantee or the
3.21 provider, vendor, or individual is correct. For any incorrect determination, the potential
3.22 grantee or the provider, vendor, or individual must submit the required information before
3.23 receiving grant funds, renewing a license, or reenrolling in a program.

3.24 (b) Notwithstanding section 16B.981, if, after reviewing the information provided under
3.25 subdivision 1, the commissioner has concerns that there is a substantial risk that a potential
3.26 grantee cannot or would not perform the required duties under the grant agreement, the
3.27 commissioner must not award the grant.

3.28 (c) If, after reviewing the information provided under subdivision 2, the commissioner
3.29 has concerns that there is a substantial risk that the provider, vendor, or individual seeking
3.30 to renew a license or reenroll in a program administered by the commissioner cannot or
3.31 would not perform the necessary duties required under the license or enrollment agreement,
3.32 the commissioner must deny the license renewal or reenrollment request.

4.1 Sec. 4. Minnesota Statutes 2024, section 245.095, is amended by adding a subdivision to
4.2 read:

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

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

4.7 Sec. 5. Minnesota Statutes 2024, section 256.01, is amended by adding a subdivision to
4.8 read:

4.9 Subd. 45. **Program integrity report.** Beginning November 30, 2026, and annually
4.10 thereafter, the commissioner must provide a report to the chairs and ranking minority
4.11 members of the legislative committees with jurisdiction over human services on program
4.12 integrity functions within the Department of Human Services. The report must include:

4.13 (1) an update from the Background Studies Division within the Office of Inspector
4.14 General at the Department of Human Services with historical metrics and descriptive data
4.15 on background studies and licensure, including the number of background studies completed
4.16 within the past five years and the number of disqualifications that occurred;

4.17 (2) an update from the Licensing Division within the Office of Inspector General at the
4.18 Department of Human Services with historical metrics and descriptive data, including the
4.19 division's capacity to meet licensing demands and data for the past five years on the number
4.20 of maltreatment reports and licensing complaints received, the results of maltreatment
4.21 investigations, the number of licenses issued for each provider type, the number of licensing
4.22 investigations and reviews completed, and the number of correction orders issued; and

4.23 (3) an update from the Financial Fraud and Abuse Investigations Division within the
4.24 Office of Inspector General at the Department of Human Services that generally includes
4.25 caseload, screening and site visit data, the number of provider medical assistance managed
4.26 care investigations within the past five years, the number of screening investigations within
4.27 the past five years, and updates on major fraud investigations.

4.28 Sec. 6. [256.0113] **ELIGIBILITY TO RECEIVE PUBLIC MONEY; PRE-AWARD**
4.29 **RISK ASSESSMENT.**

4.30 Subdivision 1. **Pre-award risk assessment; grant recipients.** (a) Prior to receiving a
4.31 grant award for a program administered by the commissioner, a potential grantee must

5.1 provide the commissioner with the applicable information specified under section 16B.981,
5.2 subdivision 2, for the most recent three-year period. This information must also include:

5.3 (1) the potential grantee's history of performing services during the most recent three-year
5.4 period that are substantially similar to the services the potential grantee is seeking to receive
5.5 public funds to provide; and

5.6 (2) for a potential grantee that is a for-profit business or nonprofit organization, evidence
5.7 of registration and good standing with the secretary of state for the most recent three-year
5.8 period, if applicable.

5.9 (b) For any information not submitted to the commissioner as required under this section
5.10 because the potential grantee determined it to be inapplicable, the potential grantee must
5.11 submit documentation noting each item that was not submitted and the reason why the
5.12 potential grantee determined it was inapplicable.

5.13 Subd. 2. **Pre-award risk assessment; licensure.** (a) Prior to renewing a license for a
5.14 program administered by the commissioner, a provider, vendor, or individual must provide
5.15 the commissioner with the applicable information specified under section 16B.981,
5.16 subdivision 2, for the most recent licensure period.

5.17 (b) Notwithstanding paragraph (a), for a provider, vendor, or individual who has been
5.18 licensed in a program administered by the commissioner for at least three years, the provider,
5.19 vendor, or individual must provide the commissioner with the applicable information
5.20 specified under section 16B.981, subdivision 2, for the most recent three-year period.

5.21 (c) For any information not submitted to the commissioner as required under this section
5.22 because the provider, vendor, or individual determined it to be inapplicable, the provider,
5.23 vendor, or individual must submit documentation noting each item that was not submitted
5.24 and the reason why the provider, vendor, or individual determined it was inapplicable.

5.25 Subd. 3. **Pre-award risk assessment; reenrollment and revalidation.** (a) Prior to
5.26 reenrollment or revalidation in a program administered by the commissioner, a provider,
5.27 vendor, or individual must provide the commissioner with the applicable information
5.28 specified under section 16B.981, subdivision 2, for the most recent enrollment period.

5.29 (b) Notwithstanding paragraph (a), for a provider, vendor, or individual who has been
5.30 enrolled in a program administered by the commissioner for at least three years, the provider,
5.31 vendor, or individual must provide the commissioner with the applicable information
5.32 specified under section 16B.981, subdivision 2, for the most recent three-year period.

6.1 (c) For any information not submitted to the commissioner as required under this section
6.2 because the provider, vendor, or individual determined it to be inapplicable, the provider,
6.3 vendor, or individual must submit documentation noting each item that was not submitted
6.4 and the reason why the provider, vendor, or individual determined it was inapplicable.

6.5 Subd. 4. **Commissioner duties.** (a) The commissioner must review all information
6.6 provided under subdivisions 1 to 3 prior to awarding a grant, renewing a license, or
6.7 reenrolling or revalidating a provider, vendor, or individual. For any documentation submitted
6.8 to the commissioner under subdivision 1, paragraph (b); subdivision 2, paragraph (c); or
6.9 subdivision 3, paragraph (c), the commissioner must review and confirm that the
6.10 determination of inapplicability made by the potential grantee or the provider, vendor, or
6.11 individual is correct. For any incorrect determination, the potential grantee or the provider,
6.12 vendor, or individual must submit the required information prior to receiving grant funds,
6.13 renewing a license, reenrollment in a program, or revalidation.

6.14 (b) Notwithstanding section 16B.981, if, after reviewing the information provided under
6.15 subdivision 1, the commissioner has concerns that there is a substantial risk that a potential
6.16 grantee cannot or would not perform the required duties under the grant agreement, the
6.17 commissioner must not award the grant.

6.18 (c) If, after reviewing the information provided under subdivision 2 or 3, the
6.19 commissioner has concerns that there is a substantial risk that the provider, vendor, or
6.20 individual seeking to renew a license, or applying for reenrollment or revalidation, cannot
6.21 or would not perform the necessary duties required under the license or enrollment agreement,
6.22 the commissioner must deny the license renewal or terminate the participation of the provider,
6.23 vendor, or individual in the program.

6.24 Sec. 7. Minnesota Statutes 2025 Supplement, section 256B.064, subdivision 1a, is amended
6.25 to read:

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

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

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

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

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

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

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

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

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

7.12 (b) For the purposes of this section, goods or services for which payment is made from
7.13 medical assistance includes but is not limited to care and services identified in section
7.14 256B.0625 or provided pursuant to any federally approved waiver.

7.15 (c) Regardless of the source of payment or other item of value, the commissioner may
7.16 impose sanctions against any individual or entity that solicits, receives, pays, or offers to
7.17 pay any illegal remuneration as described in section 142E.51, subdivision 6a, in violation
7.18 of section 609.542, subdivision 2, or in violation of United States Code, title 42, section
7.19 1320a-7b(b)(1) or (2). No conviction is required before the commissioner can impose
7.20 sanctions under this paragraph.

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

7.24 (e) The commissioner may impose sanctions against a pharmacy provider for failure to
7.25 respond to a Minnesota drug acquisition cost survey under section 256B.0625, subdivision
7.26 13e, paragraph (i).

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

7.30 Sec. 8. Minnesota Statutes 2024, section 256B.064, subdivision 1b, is amended to read:

7.31 Subd. 1b. **Sanctions available.** (a) The commissioner may impose the following sanctions
7.32 for the conduct described in subdivision 1a: ~~suspension or withholding of~~ suspending

8.1 payments to an individual or entity ~~and; withholding payments to an individual or entity;~~
 8.2 ~~suspending or terminating participation in the program;~~ terminating participation in the
 8.3 program; or imposition of imposing a fine under subdivision 2, paragraph (g) 2a.

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

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

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

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

8.15 Sec. 9. Minnesota Statutes 2024, section 256B.064, subdivision 1d, is amended to read:

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

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

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

8.24 Sec. 10. Minnesota Statutes 2024, section 256B.064, subdivision 2, is amended to read:

8.25 Subd. 2. **Imposition of monetary recovery and sanctions; generally.** (a) The
 8.26 commissioner ~~shall~~ must determine any monetary amounts to be recovered and sanctions
 8.27 to be imposed upon an individual or entity under this section. Except as provided in
 8.28 ~~paragraphs (b) and (d), neither~~ subdivisions 2b to 2d, the commissioner must not obtain a
 8.29 monetary recovery ~~nor~~ or impose a sanction ~~will be imposed by the commissioner~~ without
 8.30 prior notice and an opportunity for a hearing, according to chapter 14, on the commissioner's
 8.31 proposed action, ~~provided that the commissioner may suspend or reduce payment to an~~
 8.32 individual or entity, ~~except a nursing home or convalescent care facility, after notice and~~

9.1 ~~prior to the hearing if in the commissioner's opinion that action is necessary to protect the~~
9.2 ~~public welfare and the interests of the program.~~

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

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

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

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

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

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

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

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

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

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

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

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

9.31 ~~(d) The withholding or reduction of payments will not continue after the commissioner~~
9.32 ~~determines there is insufficient evidence of fraud by the individual or entity, or after legal~~

10.1 ~~proceedings relating to the alleged fraud are completed, unless the commissioner has sent~~
 10.2 ~~notice of intention to impose monetary recovery or sanctions under paragraph (a). Upon~~
 10.3 ~~conviction for a crime related to the provision, management, or administration of a health~~
 10.4 ~~service under medical assistance, a payment held pursuant to this section by the commissioner~~
 10.5 ~~or a managed care organization that contracts with the commissioner under section 256B.035~~
 10.6 ~~is forfeited to the commissioner or managed care organization, regardless of the amount~~
 10.7 ~~charged in the criminal complaint or the amount of criminal restitution ordered.~~

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

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

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

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

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

10.24 ~~(1) each disputed item, the reason for the dispute, and an estimate of the dollar amount~~
 10.25 ~~involved for each disputed item;~~

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

10.27 ~~(3) the authority in statute or rule upon which the individual or entity relies for each~~
 10.28 ~~disputed item;~~

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

10.31 ~~(5) other information required by the commissioner.~~

11.1 ~~(g) The commissioner may order an individual or entity to forfeit a fine for failure to~~
 11.2 ~~fully document services according to standards in this chapter and Minnesota Rules, chapter~~
 11.3 ~~9505. The commissioner may assess fines if specific required components of documentation~~
 11.4 ~~are missing. The fine for incomplete documentation shall equal 20 percent of the amount~~
 11.5 ~~paid on the claims for reimbursement submitted by the individual or entity, or up to \$5,000,~~
 11.6 ~~whichever is less. If the commissioner determines that an individual or entity repeatedly~~
 11.7 ~~violated this chapter, chapter 254B or 245G, or Minnesota Rules, chapter 9505, related to~~
 11.8 ~~the provision of services to program recipients and the submission of claims for payment,~~
 11.9 ~~the commissioner may order an individual or entity to forfeit a fine based on the nature,~~
 11.10 ~~severity, and chronicity of the violations, in an amount of up to \$5,000 or 20 percent of the~~
 11.11 ~~value of the claims, whichever is greater.~~

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

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

11.17 Sec. 11. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
 11.18 to read:

11.19 Subd. 2a. **Imposition of fines.** (a) The commissioner may order an individual or entity
 11.20 to forfeit a fine for failure to fully document services according to standards in this chapter
 11.21 and Minnesota Rules, chapter 9505. The commissioner may assess fines if specific required
 11.22 components of documentation are missing. The fine for incomplete documentation equals
 11.23 20 percent of the amount paid on the claims for reimbursement submitted by the individual
 11.24 or entity, or up to \$5,000, whichever is less. If the commissioner determines that an individual
 11.25 or entity repeatedly violated this chapter, chapter 245G or 254B, or Minnesota Rules, chapter
 11.26 9505, related to the provision of services to program recipients and the submission of claims
 11.27 for payment, the commissioner may order an individual or entity to forfeit a fine based on
 11.28 the nature, severity, and chronicity of the violations, in an amount of up to \$5,000 or 20
 11.29 percent of the value of the claims, whichever is greater.

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

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

12.1 Sec. 12. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
12.2 to read:

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

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

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

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

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

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

12.16 Sec. 13. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
12.17 to read:

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

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

12.26 (1) a nursing home;

12.27 (2) a convalescing care facility;

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

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

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

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

13.7 Sec. 14. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
13.8 to read:

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

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

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

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

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

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

13.33 (1) fraud hotline complaints;

- 14.1 (2) claims data mining;
- 14.2 (3) patterns identified through provider audits, civil false claims cases, law enforcement
- 14.3 investigations, and investigations by other state or federal agencies; and
- 14.4 (4) court filings or other legal documents.
- 14.5 (e) The commissioner must send notice of the withholding or reduction of payments
- 14.6 under paragraph (a) within five days of withholding or reducing payment unless requested
- 14.7 in writing by a law enforcement agency to temporarily withhold the notice. The notice need
- 14.8 not disclose specific information concerning an ongoing investigation. The notice must:
- 14.9 (1) state that payments are being withheld according to paragraph (a);
- 14.10 (2) set forth the allegations as to the nature of the withholding action, which must specify:
- 14.11 (i) each disputed item, and for each disputed item the reason for the dispute and an
- 14.12 estimate of the dollar amount involved;
- 14.13 (ii) the computation that the commissioner believes is correct;
- 14.14 (iii) the statute or rule the commissioner believes the individual or entity violated; and
- 14.15 (iv) other information necessary to aid the individual or entity when providing written
- 14.16 evidence under clause (5) or filing an appeal under section 256B.064, subdivision 2;
- 14.17 (3) except in the case of a conviction for conduct described in subdivision 1a, state that
- 14.18 the withholding is for a temporary period not to exceed 60 days and cite the circumstances
- 14.19 under which withholding will be terminated;
- 14.20 (4) identify the types of claims to which the withholding applies; and
- 14.21 (5) inform the individual or entity of the right to submit written evidence for consideration
- 14.22 by the commissioner.
- 14.23 (f) The commissioner must acknowledge receipt of any written evidence submitted by
- 14.24 the individual or entity within five days of receipt of the written evidence. Within five days
- 14.25 of the commissioner's acknowledgment of receipt, the commissioner must (1) cease to
- 14.26 withhold or reduce payments, or (2) respond to the individual or entity with an explanation
- 14.27 of the commissioner's continued determination that there is sufficient evidence of fraud to
- 14.28 continue withholding or reducing payments.
- 14.29 (g) The commissioner must cease to withhold or reduce payments under this subdivision
- 14.30 after 60 days have passed, after the commissioner determines there is insufficient evidence
- 14.31 of fraud by the individual or entity, or after legal proceedings relating to the alleged fraud

15.1 are completed, unless the commissioner has sent notice of intention to impose monetary
 15.2 recovery or sanctions.

15.3 Sec. 15. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
 15.4 to read:

15.5 Subd. 2e. **Forfeiture of withheld payments upon criminal conviction.** Upon conviction
 15.6 for a crime related to the provision, management, or administration of a health service under
 15.7 medical assistance, a payment held pursuant to this section by the commissioner or a managed
 15.8 care organization that contracts with the commissioner under section 256B.035 is forfeited
 15.9 to the commissioner or managed care organization, regardless of the amount charged in the
 15.10 criminal complaint or the amount of criminal restitution ordered.

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

15.12 Sec. 16. Minnesota Statutes 2024, section 256B.064, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

16.6 Sec. 17. Minnesota Statutes 2024, section 256B.064, subdivision 4, is amended to read:

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

16.10 (b) The department ~~shall~~ must give notice in writing to a recipient placed in the Minnesota
16.11 restricted recipient program under section 256B.0646 and Minnesota Rules, part 9505.2200.
16.12 The department ~~shall~~ must send the notice by first class mail to the recipient's current address
16.13 on file with the department. A recipient placed in the Minnesota restricted recipient program
16.14 may contest the placement by submitting a written request for a hearing to the department
16.15 within 90 days of the notice being mailed.

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

16.17 Sec. 18. Minnesota Statutes 2024, section 256B.064, subdivision 5, is amended to read:

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

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

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

16.28 (d) After an investigation is complete, the reporter's name must be kept confidential.
16.29 The subject of the report may compel disclosure of the reporter's name only with the consent
16.30 of the reporter or upon a written finding by a district court that the report was false and there
16.31 is evidence that the report was made in bad faith. This subdivision does not alter disclosure

17.1 responsibilities or obligations under the Rules of Criminal Procedure, except that when the
17.2 identity of the reporter is relevant to a criminal prosecution the district court ~~shall~~ must
17.3 conduct an in-camera review before determining whether to order disclosure of the reporter's
17.4 identity.

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

17.6 Sec. 19. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; MEDICAL**
17.7 **ASSISTANCE PROVIDER ENROLLMENT STANDARDS.**

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

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

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

17.21 Sec. 20. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; PROGRAM**
17.22 **INTEGRITY TECHNOLOGY MODERNIZATION.**

17.23 By January 1, 2027, the commissioner of human services must develop recommendations
17.24 on how to modernize program integrity infrastructure within the Department of Human
17.25 Services. The recommendations must include the infrastructure's capability to provide
17.26 near-real-time analytics and risk scoring; prepayment review and anomaly detection;
17.27 cross-matching of enrollment data, licensure data, and claims data; and security dashboards
17.28 for audits and investigations with privacy safeguards. By January 15, 2027, the commissioner
17.29 must provide recommendations to the chairs and ranking minority members of the legislative
17.30 committees with jurisdiction over human services program integrity functions.

18.1 Sec. 21. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; PROGRAM**
18.2 **STRUCTURE AND DESIGN AUDITS.**

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

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

18.10 (1) adult companion services;

18.11 (2) adult day services;

18.12 (3) adult rehabilitative mental health services;

18.13 (4) assertive community treatment;

18.14 (5) community first services and supports;

18.15 (6) early intensive developmental and behavioral intervention;

18.16 (7) individualized home supports;

18.17 (8) integrated community supports;

18.18 (9) intensive residential treatment services;

18.19 (10) night supervision services;

18.20 (11) nonemergency medical transportation services;

18.21 (12) peer recovery support services; and

18.22 (13) recuperative care.

18.23 (c) Each audit must be completed by January 1, 2027. The commissioner must submit
18.24 each completed audit report within 30 days of receipt to the chairs and ranking minority
18.25 members of the legislative committees with jurisdiction over human services program
18.26 integrity functions.

19.1

ARTICLE 2

19.2

MEDICAL ASSISTANCE PROVIDER ENROLLMENT MODIFICATIONS

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

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

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

19.9 (2) the individual designated as the authorized agent under section 142B.10, subdivision
19.10 1, paragraph (b);

19.11 (3) the individual designated as the compliance officer under section ~~256B.04, subdivision~~
19.12 ~~21, paragraph (g)~~ 256B.044, subdivision 8, paragraph (b);

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

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

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

19.18 (b) Controlling individual does not include:

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

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

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

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

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

20.1 (4) an individual who is a member of an organization exempt from taxation under section
 20.2 290.05, unless the individual is also an officer, owner, or managerial official of the program
 20.3 or owns any of the beneficial interests not excluded in this subdivision. This clause does
 20.4 not exclude from the definition of controlling individual an organization that is exempt from
 20.5 taxation; or

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

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

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

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

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

20.20 (2) the individual designated as the authorized agent under section 245A.04, subdivision
 20.21 1, paragraph (b);

20.22 (3) the individual designated as the compliance officer under section ~~256B.04, subdivision~~
 20.23 ~~21, paragraph (g)~~ 256B.044, subdivision 8, paragraph (b);

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

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

20.27 (b) Controlling individual does not include:

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

20.31 (2) an individual who is a state or federal official, or state or federal employee, or a
 20.32 member or employee of the governing body of a political subdivision of the state or federal

21.1 government that operates one or more programs, unless the individual is also an officer,
 21.2 owner, or managerial official of the program, receives remuneration from the program, or
 21.3 owns any of the beneficial interests not excluded in this subdivision;

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

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

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

21.8 (4) an individual who is a member of an organization exempt from taxation under section
 21.9 290.05, unless the individual is also an officer, owner, or managerial official of the program
 21.10 or owns any of the beneficial interests not excluded in this subdivision. This clause does
 21.11 not exclude from the definition of controlling individual an organization that is exempt from
 21.12 taxation; or

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

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

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

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

21.26 (1) maintaining a current understanding of the licensing requirements sufficient to ensure
 21.27 compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph
 21.28 (e), and when applicable, as identified in section ~~256B.04, subdivision 21, paragraph (g)~~
 21.29 256B.044, subdivision 8;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25.20 ~~(j) As a condition of enrollment in medical assistance, the commissioner shall require~~
25.21 ~~that a provider designated "moderate" or "high-risk" by the Centers for Medicare and~~
25.22 ~~Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid~~
25.23 ~~Services, its agents, or its designated contractors and the state agency, its agents, or its~~
25.24 ~~designated contractors to conduct unannounced on-site inspections of any provider location.~~
25.25 ~~The commissioner shall publish in the Minnesota Health Care Program Provider Manual a~~
25.26 ~~list of provider types designated "limited," "moderate," or "high-risk," based on the criteria~~
25.27 ~~and standards used to designate Medicare providers in Code of Federal Regulations, title~~
25.28 ~~42, section 424.518. The list and criteria are not subject to the requirements of chapter 14.~~
25.29 ~~The commissioner's designations are not subject to administrative appeal.~~

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

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

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

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

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

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

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

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

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

27.9 (b) The list and criteria are not subject to the requirements of chapter 14, and section
27.10 14.386 does not apply.

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

27.12 Subd. 2. Required verifications and checks. The commissioner must perform the
27.13 following verifications and checks prior to making an enrollment determination and
27.14 periodically thereafter:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

29.10 (3) unannounced site visits, as follows:

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

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

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

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

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

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

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

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

29.26 (3) the provider or category of providers is designated high-risk pursuant to subdivision
 29.27 1.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

32.3 **Sec. 8. [256B.0442] PROVIDER ENROLLMENT SUSPENSIONS AND**
 32.4 **TERMINATIONS.**

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

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

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

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

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

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

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

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

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

33.1 unless the commissioner determines that denial or termination of enrollment is not in the
33.2 best interests of the medical assistance program and the commissioner documents that
33.3 determination in writing;

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

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

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

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

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

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

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

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

33.31 (3) serves primarily a pediatric population.

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

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

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

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

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

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

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

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

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

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

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

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

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

35.2 The report must include, at a minimum:

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

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

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

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

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

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

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

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

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

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

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

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

36.28 (c) For outpatient individual and group substance use disorder services under section
36.29 254B.0505, subdivision 1, clause (1), and adolescent treatment programs that are licensed
36.30 as outpatient treatment programs according to sections 245G.01 to 245G.18, provided on
36.31 or after January 1, 2021, payment rates must be increased by 20 percent over the rates in
36.32 effect on December 31, 2020.

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

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

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

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

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

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

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

37.27 (2) designate an individual as the agency's compliance officer who must perform the
 37.28 duties described in section ~~256B.04, subdivision 21, paragraph (g)~~ 256B.044, subdivision
 37.29 8, paragraph (b);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

40.6 (b) The commissioner, in consultation with the Early Intensive Developmental and
 40.7 Behavioral Intervention Advisory Council and stakeholders, must establish processes and
 40.8 criteria for granting an exception under this paragraph. The commissioner may grant an
 40.9 exception only if the exception would not compromise a person's safety and not diminish
 40.10 the effectiveness of the treatment. The commissioner may establish an expiration date for
 40.11 an exception granted under this paragraph. The commissioner may grant an exception for
 40.12 the following:

40.13 (1) EIDBI provider qualifications under this section;

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

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

40.17 (c) If the commissioner, in consultation with the Early Intensive Developmental and
 40.18 Behavioral Intervention Advisory Council and stakeholders, determines that a shortage no
 40.19 longer exists, the commissioner must submit a notice that a shortage no longer exists to the
 40.20 chairs and ranking minority members of the senate and the house of representatives
 40.21 committees with jurisdiction over health and human services. The commissioner must post
 40.22 the notice for public comment for 30 days. The commissioner shall consider public comments
 40.23 before submitting to the legislature a request to end the shortage declaration. The
 40.24 commissioner shall not declare the shortage of EIDBI providers ended without direction
 40.25 from the legislature to declare it ended.

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

40.27 The commissioner of human services must amend Minnesota Rules, part 9505.2165,
 40.28 subpart 4, item C, to remove the citation to United States Code, title 42, section
 40.29 1320a-7b(b)(3)(D), and insert a citation to United States Code, title 42, section 1320a-7b(b).
 40.30 The commissioner may use the procedure under Minnesota Statutes, section 14.388,
 40.31 subdivision 1, clause (3), for changes to Minnesota Rules pursuant to this section. Minnesota
 40.32 Statutes, section 14.386, does not apply to rules adopted pursuant to this section except as
 40.33 provided under Minnesota Statutes, section 14.388.

41.1 **ARTICLE 3**

41.2 **PROVIDER ENROLLMENT REQUIREMENTS FOR HIGH-RISK PROVIDERS**

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

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

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

41.9 (2) the individual designated as the authorized agent under section 142B.10, subdivision
41.10 1, paragraph (b);

41.11 (3) the individual designated as the compliance officer under section ~~256B.04, subdivision~~
41.12 ~~21, paragraph (g)~~ 256B.044, subdivision 7, paragraph (b);

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

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

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

41.18 (b) Controlling individual does not include:

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

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

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

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

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

42.1 (4) an individual who is a member of an organization exempt from taxation under section
 42.2 290.05, unless the individual is also an officer, owner, or managerial official of the program
 42.3 or owns any of the beneficial interests not excluded in this subdivision. This clause does
 42.4 not exclude from the definition of controlling individual an organization that is exempt from
 42.5 taxation; or

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

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

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

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

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

42.20 (2) the individual designated as the authorized agent under section 245A.04, subdivision
 42.21 1, paragraph (b);

42.22 (3) the individual designated as the compliance officer under section ~~256B.04, subdivision~~
 42.23 ~~21, paragraph (g)~~ 256B.044, subdivision 7, paragraph (b);

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

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

42.27 (b) Controlling individual does not include:

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

42.31 (2) an individual who is a state or federal official, or state or federal employee, or a
 42.32 member or employee of the governing body of a political subdivision of the state or federal

43.1 government that operates one or more programs, unless the individual is also an officer,
43.2 owner, or managerial official of the program, receives remuneration from the program, or
43.3 owns any of the beneficial interests not excluded in this subdivision;

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

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

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

43.8 (4) an individual who is a member of an organization exempt from taxation under section
43.9 290.05, unless the individual is also an officer, owner, or managerial official of the program
43.10 or owns any of the beneficial interests not excluded in this subdivision. This clause does
43.11 not exclude from the definition of controlling individual an organization that is exempt from
43.12 taxation; or

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

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

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

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

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

44.8 When the commissioner receives an application for initial licensure that is incomplete
44.9 because the applicant failed to submit required documents or that is substantially deficient
44.10 because the documents submitted do not meet licensing requirements, the commissioner
44.11 shall provide the applicant written notice that the application is incomplete or substantially
44.12 deficient. In the written notice to the applicant the commissioner shall identify documents
44.13 that are missing or deficient and give the applicant 45 days to resubmit a second application
44.14 that is substantially complete. An applicant's failure to submit a substantially complete
44.15 application after receiving notice from the commissioner is a basis for license denial under
44.16 section 245A.043.

44.17 (b) An application for licensure must identify all controlling individuals as defined in
44.18 section 245A.02, subdivision 5a, and must designate one individual to be the authorized
44.19 agent. The application must be signed by the authorized agent and must include the authorized
44.20 agent's first, middle, and last name; mailing address; and email address. By submitting an
44.21 application for licensure, the authorized agent consents to electronic communication with
44.22 the commissioner throughout the application process. The authorized agent must be
44.23 authorized to accept service on behalf of all of the controlling individuals. A government
44.24 entity that holds multiple licenses under this chapter may designate one authorized agent
44.25 for all licenses issued under this chapter or may designate a different authorized agent for
44.26 each license. Service on the authorized agent is service on all of the controlling individuals.
44.27 It is not a defense to any action arising under this chapter that service was not made on each
44.28 controlling individual. The designation of a controlling individual as the authorized agent
44.29 under this paragraph does not affect the legal responsibility of any other controlling individual
44.30 under this chapter.

44.31 (c) An applicant or license holder must have a policy that prohibits license holders,
44.32 employees, subcontractors, and volunteers, when directly responsible for persons served
44.33 by the program, from abusing prescription medication or being in any manner under the
44.34 influence of a chemical that impairs the individual's ability to provide services or care. The
44.35 license holder must train employees, subcontractors, and volunteers about the program's

45.1 drug and alcohol policy before the employee, subcontractor, or volunteer has direct contact,
45.2 as defined in section 245C.02, subdivision 11, with a person served by the program.

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

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

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

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

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

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

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

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

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

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

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

46.1 (3) the first, middle, and last name, and address for all individuals who will be controlling
46.2 individuals, including all officers, owners, and managerial officials as defined in section
46.3 245A.02, subdivision 5a, and the date that the background study was initiated by the applicant
46.4 for each controlling individual;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

47.14 (1) the application;

47.15 (2) the renewal;

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

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

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

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

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

47.26 (1) the name of the license holder;

47.27 (2) the address of the program;

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

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

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

48.3 (6) any special conditions of licensure.

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

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

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

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

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

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

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

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

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

48.19 (4) failed to submit the information required of an applicant under subdivision 1,
48.20 paragraph (f), (g), ~~or (h)~~, or (j), after being requested by the commissioner.

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

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

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

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

49.12 (h) The commissioner shall not issue or reissue a license under this chapter if an individual
49.13 living in the household where the services will be provided as specified under section
49.14 245C.03, subdivision 1, has been disqualified and the disqualification has not been set aside
49.15 and no variance has been granted.

49.16 (i) Pursuant to section 245A.07, subdivision 1, paragraph (b), when a license issued
49.17 under this chapter has been suspended or revoked and the suspension or revocation is under
49.18 appeal, the program may continue to operate pending a final order from the commissioner.
49.19 If the license under suspension or revocation will expire before a final order is issued, a
49.20 temporary provisional license may be issued provided any applicable license fee is paid
49.21 before the temporary provisional license is issued.

49.22 (j) Notwithstanding paragraph (i), when a revocation is based on the disqualification of
49.23 a controlling individual or license holder, and the controlling individual or license holder
49.24 is ordered under section 245C.17 to be immediately removed from direct contact with
49.25 persons receiving services or is ordered to be under continuous, direct supervision when
49.26 providing direct contact services, the program may continue to operate only if the program
49.27 complies with the order and submits documentation demonstrating compliance with the
49.28 order. If the disqualified individual fails to submit a timely request for reconsideration, or
49.29 if the disqualification is not set aside and no variance is granted, the order to immediately
49.30 remove the individual from direct contact or to be under continuous, direct supervision
49.31 remains in effect pending the outcome of a hearing and final order from the commissioner.

49.32 (k) Unless otherwise specified by statute, all licenses issued under this chapter expire
49.33 at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must
49.34 comply with the requirements in section 245A.10 and be reissued a new license to operate

50.1 the program or the program must not be operated after the expiration date. Adult foster care,
50.2 family adult day services, child foster residence setting, and community residential services
50.3 license holders must apply for and be granted a new license to operate the program or the
50.4 program must not be operated after the expiration date. Upon implementation of the provider
50.5 licensing and reporting hub, licenses may be issued each calendar year.

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

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

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

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

50.15 **245A.05 DENIAL OF APPLICATION.**

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

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

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

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

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

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

50.28 (6) is associated with an individual who received a background study under section
50.29 245C.03, subdivision 1, paragraph (a), clause (6), who may have unsupervised access to
50.30 children or vulnerable adults, and who has a disqualification that has not been set aside
50.31 under section 245C.22, and no variance has been granted;

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

51.2 (8) fails to demonstrate competent knowledge as required by section 245A.04, subdivision
51.3 6;

51.4 (9) has a history of noncompliance as a license holder or controlling individual with
51.5 applicable laws or rules, including but not limited to this chapter and chapters 142E and
51.6 245C;

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

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

51.9 (b) An applicant whose application has been denied by the commissioner must be given
51.10 notice of the denial, which must state the reasons for the denial in plain language. Notice
51.11 must be given by certified mail, by personal service, or through the provider licensing and
51.12 reporting hub. The notice must state the reasons the application was denied and must inform
51.13 the applicant of the right to a contested case hearing under chapter 14 and Minnesota Rules,
51.14 parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the
51.15 commissioner in writing by certified mail, by personal service, or through the provider
51.16 licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the
51.17 commissioner within 20 calendar days after the applicant received the notice of denial. If
51.18 an appeal request is made by personal service, it must be received by the commissioner
51.19 within 20 calendar days after the applicant received the notice of denial. If the order is issued
51.20 through the provider hub, the appeal must be received by the commissioner within 20
51.21 calendar days from the date the commissioner issued the order through the hub. Section
51.22 245A.08 applies to hearings held to appeal the commissioner's denial of an application.

51.23 Sec. 6. Minnesota Statutes 2024, section 245D.081, subdivision 3, is amended to read:

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

51.28 (1) maintaining a current understanding of the licensing requirements sufficient to ensure
51.29 compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph
51.30 (e), and when applicable, as identified in section ~~256B.04, subdivision 21, paragraph (g)~~
51.31 256B.044, subdivision 7;

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

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

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

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

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

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

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

52.21 Sec. 7. Minnesota Statutes 2025 Supplement, section 256B.04, subdivision 21, is amended
 52.22 to read:

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

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

53.1 ~~the provider that includes a review of databases in section 245C.08, subdivision 1, paragraph~~
53.2 ~~(a), clauses (1) to (5).~~

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

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

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

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

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

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

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

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

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

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

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

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

53.30 ~~(g) An enrolled provider that is also licensed by the commissioner under chapter 245A,~~
53.31 ~~is licensed as a home care provider by the Department of Health under chapter 144A, or is~~
53.32 ~~licensed as an assisted living facility under chapter 144G and has a home and~~

54.1 ~~community-based services designation on the home care license under section 144A.484,~~
 54.2 ~~must designate an individual as the entity's compliance officer. The compliance officer~~
 54.3 ~~must:~~

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

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

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

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

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

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

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

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

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

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

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

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

55.6 ~~(j) As a condition of enrollment in medical assistance, the commissioner shall require~~
55.7 ~~that a provider designated "moderate" or "high-risk" by the Centers for Medicare and~~
55.8 ~~Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid~~
55.9 ~~Services, its agents, or its designated contractors and the state agency, its agents, or its~~
55.10 ~~designated contractors to conduct unannounced on-site inspections of any provider location.~~
55.11 ~~The commissioner shall publish in the Minnesota Health Care Program Provider Manual a~~
55.12 ~~list of provider types designated "limited," "moderate," or "high-risk," based on the criteria~~
55.13 ~~and standards used to designate Medicare providers in Code of Federal Regulations, title~~
55.14 ~~42, section 424.518. The list and criteria are not subject to the requirements of chapter 14.~~
55.15 ~~The commissioner's designations are not subject to administrative appeal.~~

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

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

55.31 ~~(2) At the time of initial enrollment or reenrollment, durable medical equipment providers~~
55.32 ~~and suppliers defined in clause (3) must purchase a surety bond of \$50,000. If a revalidating~~
55.33 ~~provider's Medicaid revenue in the previous calendar year is up to and including \$300,000,~~
55.34 ~~the provider agency must purchase a surety bond of \$50,000. If a revalidating provider's~~

56.1 ~~Medicaid revenue in the previous calendar year is over \$300,000, the provider agency must~~
 56.2 ~~purchase a surety bond of \$100,000. The surety bond must allow for recovery of costs and~~
 56.3 ~~fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions~~
 56.4 ~~from a surety bond must occur within six years from the date the debt is affirmed by a final~~
 56.5 ~~agency decision. An agency decision is final when the right to appeal the debt has been~~
 56.6 ~~exhausted or the time to appeal has expired under section 256B.064.~~

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

56.11 ~~(m) The Department of Human Services may require a provider to purchase a surety~~
 56.12 ~~bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment~~
 56.13 ~~if: (1) the provider fails to demonstrate financial viability, (2) the department determines~~
 56.14 ~~there is significant evidence of or potential for fraud and abuse by the provider, or (3) the~~
 56.15 ~~provider or category of providers is designated high-risk pursuant to paragraph (f) and as~~
 56.16 ~~per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in an~~
 56.17 ~~amount of \$100,000 or ten percent of the provider's payments from Medicaid during the~~
 56.18 ~~immediately preceding 12 months, whichever is greater. The surety bond must name the~~
 56.19 ~~Department of Human Services as an obligee and must allow for recovery of costs and fees~~
 56.20 ~~in pursuing a claim on the bond. This paragraph does not apply if the provider currently~~
 56.21 ~~maintains a surety bond under the requirements in section 256B.051, 256B.0659, 256B.0701,~~
 56.22 ~~or 256B.85.~~

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

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

56.29 (b) The list and criteria are not subject to the requirements of chapter 14, and section
 56.30 14.386 does not apply.

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

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

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

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

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

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

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

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

57.21 (3) the provider or category of providers is designated high-risk pursuant to subdivision
57.22 1 and Code of Federal Regulations, title 42, section 455.450.

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

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

57.29 Subd. 6. **Required permission to conduct on-site inspection.** As a condition of
57.30 enrollment in medical assistance, the commissioner shall require that a provider designated
57.31 moderate-risk or high-risk by CMS or the commissioner permit CMS, CMS's agents, or
57.32 CMS's designated contractors and the state agency, the state agency's agents, or the state

58.1 agency's designated contractors to conduct unannounced on-site inspections of any provider
58.2 location.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

59.5 Subd. 2. **Revalidation procedures.** The commissioner shall conduct revalidation as
 59.6 follows:

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

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

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

59.15 Sec. 10. **[256B.0442] PROVIDER ENROLLMENT SUSPENSIONS AND**
 59.16 **TERMINATIONS.**

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

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

59.23 Subd. 2. **Commissioner's authority to revoke enrollment of certain providers for**
 59.24 **lack of documentation.** (a) The commissioner may revoke the enrollment of an ordering
 59.25 or rendering provider for a period of not more than one year if the provider fails to maintain
 59.26 and, upon request from the commissioner, provide access to documentation relating to
 59.27 written orders or requests for payment for durable medical equipment, certifications for
 59.28 home health services, or referrals for other items or services written or ordered by the
 59.29 provider, when the commissioner has identified a pattern of a lack of documentation. A
 59.30 pattern means a failure to maintain documentation or provide access to documentation on
 59.31 more than one occasion.

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

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

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

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

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

60.14 (3) serves primarily a pediatric population.

60.15 **Sec. 11. [256B.0443] PROVIDER PAYMENT WITHHOLDS UPON INITIAL**
 60.16 **ENROLLMENT.**

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

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

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

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

60.29 Subd. 2. Mandatory training compliance. (a) Effective January 1, 2027, before applying
 60.30 for enrollment or reenrollment as a medical assistance provider, an agency applying to
 60.31 provide services designated by the commissioner as high-risk must require all owners of

61.1 the agency who are active in the day-to-day management and operations of the agency and
61.2 managerial and supervisory employees to complete compliance training. All individuals
61.3 who must complete training under this subdivision must repeat the training prior to
61.4 revalidation of the agency as a medical assistance provider.

61.5 (b) New owners active in day-to-day management and operations of the agency and new
61.6 managerial and supervisory employees of the agency must complete compliance training
61.7 under this subdivision within 30 calendar days of becoming an owner of or employed by
61.8 the agency and prior to conducting any management and operations activities for the agency.
61.9 If an individual moves to another agency providing the same service and serves in a similar
61.10 ownership or employment capacity, the individual is not required to repeat the training
61.11 required under this subdivision. If the individual chooses not to repeat the compliance
61.12 training, the individual must provide the agency with documentation proving the individual
61.13 completed the compliance training within the provider revalidation schedule for the relevant
61.14 provider type as determined by the commissioner under section 256B.0441.

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

- 61.18 (1) state and federal program billing, documentation, and service delivery requirements;
61.19 (2) enrollment requirements;
61.20 (3) provider program integrity, including fraud prevention, detection, and penalties;
61.21 (4) fair labor standards;
61.22 (5) workplace safety requirements; and
61.23 (6) recent changes in service requirements.

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

61.27 (b) The commissioner must issue a unique Minnesota provider identifier to each
61.28 individual who satisfies the background study requirements, satisfies the individual
61.29 enrollment requirements, and does not have either a national provider identifier or a unique
61.30 Minnesota provider identifier. The commissioner must ensure that no individual is issued
61.31 multiple unique Minnesota provider identifiers. If the commissioner mistakenly issues
61.32 multiple unique Minnesota provider identifiers to the same individual, the commissioner
61.33 must provide a means for the numbers to be consolidated.

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

62.4 Subd. 4. **Required use of an electronic visit verification system.** Effective January 1,
 62.5 2027, an individual providing a high-risk service must electronically verify the provision
 62.6 of the services using an electronic visit verification system meeting the requirements of
 62.7 section 256B.073.

62.8 Subd. 5. **Signatures required for provision of service verifications.** (a) Effective
 62.9 January 1, 2027, an individual providing a high-risk service must sign and obtain the
 62.10 signature of the service recipient, or of the service recipient's representative, on a provision
 62.11 of service verification form. The provision of service verification form must include a
 62.12 statement that by signing the form, the signatory is attesting to the accuracy of all data
 62.13 entered in the electronic visit verification system. The provision of service verification form
 62.14 must also include a statement that it is a federal crime to provide false information regarding
 62.15 the provision of medical assistance services.

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

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

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

62.23 (2) the origination site; and

62.24 (3) the destination site.

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

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

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

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

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

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

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

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

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

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

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

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

64.7 (5) provides at the time of enrollment, reenrollment, and revalidation in a format
64.8 determined by the commissioner, proof of surety bond coverage for each business location
64.9 providing services. Upon new enrollment, or if the provider's medical assistance revenue
64.10 in the previous calendar year is \$300,000 or less, the provider agency must purchase a surety
64.11 bond of \$50,000. If the provider's medical assistance revenue in the previous year is over
64.12 \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety bond
64.13 must be in a form approved by the commissioner, must be renewed annually, and must
64.14 allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain
64.15 monetary recovery or sanctions from a surety bond must occur within six years from the
64.16 date the debt is affirmed by a final agency decision. An agency decision is final when the
64.17 right to appeal the debt has been exhausted or the time to appeal has expired under section
64.18 256B.064;

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

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

64.23 (8) completes compliance training as required under section 256B.0444, subdivision ~~6~~
64.24 2.

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

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

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

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

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

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

65.5 (5) provides at the time of enrollment, reenrollment, and revalidation in a format
65.6 determined by the commissioner, proof of surety bond coverage for each business location
65.7 providing services. Upon new enrollment, or if the provider's medical assistance revenue
65.8 in the previous calendar year is \$300,000 or less, the provider agency must purchase a surety
65.9 bond of \$50,000. If the provider's medical assistance revenue in the previous year is over
65.10 \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety bond
65.11 must be in a form approved by the commissioner, must be renewed annually, and must
65.12 allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain
65.13 monetary recovery or sanctions from a surety bond must occur within six years from the
65.14 date the debt is affirmed by a final agency decision. An agency decision is final when the
65.15 right to appeal the debt has been exhausted or the time to appeal has expired under section
65.16 256B.064;

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

65.19 (7) completes compliance training as required under section 256B.0444, subdivision ~~4~~
65.20 2; and

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

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

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

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

65.26 (1) type of service performed;

65.27 (2) individual receiving the service;

65.28 (3) date of the service;

65.29 (4) location of the service delivery;

65.30 (5) individual providing the service; and

65.31 (6) time the service begins and ends.

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

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

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

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

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

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

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

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

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

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

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

67.5 (c) For outpatient individual and group substance use disorder services under section
67.6 254B.0505, subdivision 1, clause (1), and adolescent treatment programs that are licensed
67.7 as outpatient treatment programs according to sections 245G.01 to 245G.18, provided on
67.8 or after January 1, 2021, payment rates must be increased by 20 percent over the rates in
67.9 effect on December 31, 2020.

67.10 (d) Effective January 1, 2021, and contingent on annual federal approval, managed care
67.11 plans and county-based purchasing plans must reimburse providers of the substance use
67.12 disorder services meeting the criteria described in paragraph (a) who are employed by or
67.13 under contract with the plan an amount that is at least equal to the fee-for-service base rate
67.14 payment for the substance use disorder services described in paragraph (c). The commissioner
67.15 must monitor the effect of this requirement on the rate of access to substance use disorder
67.16 services and residential substance use disorder rates. Capitation rates paid to managed care
67.17 organizations and county-based purchasing plans must reflect the impact of this requirement.
67.18 This paragraph expires if federal approval is not received at any time as required under this
67.19 paragraph.

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

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

67.31 Sec. 18. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 16, is
67.32 amended to read:

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

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

68.4 (2) designate an individual as the agency's compliance officer who must perform the
68.5 duties described in section ~~256B.04, subdivision 21, paragraph (g)~~ 256B.044, subdivision
68.6 7, paragraph (b);

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

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

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

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

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

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

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

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

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

68.30 (12) have a written policy to resolve issues collaboratively with the person and the
68.31 person's legal representative when possible. The policy must include a timeline for when

69.1 the person and the person's legal representative will be notified about issues that arise in
69.2 the provision of services;

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

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

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

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

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

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

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

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

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

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

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

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

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

70.5 Subd. 17. **Provider shortage; authority for exceptions.** (a) In consultation with the
70.6 Early Intensive Developmental and Behavioral Intervention Advisory Council and
70.7 stakeholders, including agencies, professionals, parents of people with ASD or a related
70.8 condition, and advocacy organizations, the commissioner shall determine if a shortage of
70.9 EIDBI providers exists. For the purposes of this subdivision, "shortage of EIDBI providers"
70.10 means a lack of availability of providers who meet the EIDBI provider qualification
70.11 requirements under subdivision 15 that results in the delay of access to timely services under
70.12 this section, or that significantly impairs the ability of a provider agency to have sufficient
70.13 providers to meet the requirements of this section. The commissioner shall consider
70.14 geographic factors when determining the prevalence of a shortage. The commissioner may
70.15 determine that a shortage exists only in a specific region of the state, multiple regions of
70.16 the state, or statewide. The commissioner shall also consider the availability of various types
70.17 of treatment modalities covered under this section.

70.18 (b) The commissioner, in consultation with the Early Intensive Developmental and
70.19 Behavioral Intervention Advisory Council and stakeholders, must establish processes and
70.20 criteria for granting an exception under this paragraph. The commissioner may grant an
70.21 exception only if the exception would not compromise a person's safety and not diminish
70.22 the effectiveness of the treatment. The commissioner may establish an expiration date for
70.23 an exception granted under this paragraph. The commissioner may grant an exception for
70.24 the following:

70.25 (1) EIDBI provider qualifications under this section;

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

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

70.29 (c) If the commissioner, in consultation with the Early Intensive Developmental and
70.30 Behavioral Intervention Advisory Council and stakeholders, determines that a shortage no
70.31 longer exists, the commissioner must submit a notice that a shortage no longer exists to the
70.32 chairs and ranking minority members of the senate and the house of representatives
70.33 committees with jurisdiction over health and human services. The commissioner must post

71.1 the notice for public comment for 30 days. The commissioner shall consider public comments
 71.2 before submitting to the legislature a request to end the shortage declaration. The
 71.3 commissioner shall not declare the shortage of EIDBI providers ended without direction
 71.4 from the legislature to declare it ended.

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

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

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

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

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

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

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

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

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

71.29 Subd. 10a. Individual provider identifier. (a) Effective January 1, 2027, staff that
 71.30 provide direct contact, as defined in section 245C.02, subdivision 11, for services specified
 71.31 in the federally approved waiver plans must enroll individually with Minnesota health care

72.1 programs as a medical assistance provider. This requirement also applies to
 72.2 consumer-directed community supports.

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

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

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

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

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

72.15 (1) the date the documentation occurred;

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

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

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

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

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

72.28 (1) the date the documentation occurred;

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

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

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

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

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

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

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

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

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

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

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

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

73.25 Subd. 15. **Adult day service documentation and billing requirements.** (a) In addition
 73.26 to the requirements in subdivision 12, a provider of adult day services as defined in section
 73.27 245A.02, subdivision 2a, and licensed under Minnesota Rules, parts 9555.9600 to 9555.9730,
 73.28 must maintain documentation of:

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

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

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

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

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

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

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

74.19 The owners and employees of any medical assistance provider agency subject to the
 74.20 requirements of Minnesota Statutes, section 256B.0444, subdivision 2, and enrolled before
 74.21 January 1, 2027, must complete initial compliance training by January 1, 2028. Owners and
 74.22 employees of PCA and CFSS agencies who enrolled before January 1, 2027, and have
 74.23 previously completed training under Minnesota Statutes, section 256B.0659, subdivision
 74.24 21, paragraph (c), or 256B.85, subdivision 12, paragraph (c), are not subject to the initial
 74.25 training requirements of this section but must repeat the compliance training prior to
 74.26 revalidation as a medical assistance provider.

74.27 **Sec. 26. DIRECTION TO COMMISSIONER OF HUMAN SERVICES;**
 74.28 **UNREDACTED INITIAL OPTUM REPORTS.**

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

75.1 (b) Notwithstanding any law to the contrary, upon a joint request by both the chairs and
75.2 ranking minority members of a legislative committee with jurisdiction over human services
75.3 policy and finance, the commissioner of human services must immediately release the initial
75.4 Optum reports to the members of that legislative committee in the reports' entirety without
75.5 redactions or edits, except for redactions requested by Optum to protect proprietary
75.6 information. Legislators or legislative staff who receive initial Optum reports under this
75.7 section must not disseminate or publicize any not public data, as defined in Minnesota
75.8 Statutes, section 13.02, subdivision 8a, that the reports contain.

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

75.10 Sec. 27. **OPTUM PROHIBITED FROM DISSEMINATING PRIVATE DATA.**

75.11 Optum, Inc., must not sell, share, or disseminate any private data on individuals, as
75.12 defined in Minnesota Statutes, section 13.02, subdivision 12, that Optum receives under or
75.13 incidental to Optum's contract or engagement with the Department of Human Services
75.14 pursuant to the governor's Executive Order No. 25-10.

75.15 Sec. 28. **REPEALER.**

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

APPENDIX
Article locations for S4222-2

ARTICLE 1	PROGRAM INTEGRITY REQUIREMENTS.....	Page.Ln 1.22
	MEDICAL ASSISTANCE PROVIDER ENROLLMENT	
ARTICLE 2	MODIFICATIONS.....	Page.Ln 19.1
	PROVIDER ENROLLMENT REQUIREMENTS FOR HIGH-RISK	
ARTICLE 3	PROVIDERS.....	Page.Ln 41.1

256B.051 HOUSING STABILIZATION SERVICES.

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

- (1) state and federal program billing, documentation, and service delivery requirements;
- (2) enrollment requirements;
- (3) provider program integrity, including fraud prevention, detection, and penalties;
- (4) fair labor standards;
- (5) workplace safety requirements; and
- (6) recent changes in service requirements.

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

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

256B.0701 RECUPERATIVE CARE SERVICES.

Subd. 11. **Requirements for provider enrollment; compliance training.** (a) Effective January 1, 2027, to enroll as a recuperative care provider, a provider must require all owners of the provider who are active in the day-to-day management and operations of the agency and all managerial and supervisory employees to complete compliance training before applying for enrollment and every three years thereafter. Mandatory compliance training format and content must be determined by the commissioner and must include the following topics:

- (1) state and federal program billing, documentation, and service delivery requirements;
- (2) enrollment requirements;
- (3) provider program integrity, including fraud prevention, detection, and penalties;
- (4) fair labor standards;
- (5) workplace safety requirements; and
- (6) recent changes in service requirements.

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

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