

256B.044 PROVIDER ENROLLMENT.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 5. Required on-site inspections. (a) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated as moderate-risk or high-risk by CMS or the commissioner permit CMS, CMS's agents, or CMS's designated contractors and the state agency, the state agency's agents, or the state agency's designated contractors to conduct unannounced on-site inspections of any provider location.

(b) Consistent with the commissioner's authority under Code of Federal Regulations, title 42, section 455.452, prior to enrolling, prior to reenrolling, and prior to revalidating a provider designated as moderate-risk or high-risk, the commissioner must conduct unannounced on-site inspections of all provider locations.

Subd. 6. Surety bonds. (a) The commissioner must require a provider to purchase a surety bond as a condition of initial enrollment, reenrollment, revalidation, reinstatement, or continued enrollment. Upon new enrollment, or if the provider's medical assistance revenue in the previous calendar year is less than or equal to \$300,000, the provider must purchase a surety bond of \$50,000. If the provider's medical assistance revenue in the previous calendar year is greater than \$300,000, the provider must purchase a surety bond of \$100,000. The surety bond must name the Department of Human Services as an obligee, must be purchased new annually, and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions from a surety bond must occur within six years from the date the debt is affirmed by a final agency decision. An agency decision is final when the right to appeal the debt has been exhausted or the time to appeal has expired under section 256B.064.

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

Subd. 7. Financial capacity. As a condition of enrolling in medical assistance, the commissioner must require, in a form and manner prescribed by the commissioner, that a provider attest to sufficient financial capacity to operate.

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

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

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

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

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

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

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

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

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

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

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

History: 2026 c 121 art 3 s 18