

1.1 Senator moves to amend S.F. No. 4222 as follows:

1.2 Delete everything after the enacting clause and insert:

1.3 "ARTICLE 1

1.4 PROGRAM INTEGRITY REQUIREMENTS

1.5 Section 1. Minnesota Statutes 2025 Supplement, section 15.013, is amended by adding a
1.6 subdivision to read:

1.7 Subd. 7. Exemption. Nothing in this section modifies, supersedes, limits, or expands
1.8 the authority of the commissioner of human services to impose sanctions under section
1.9 256B.064.

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

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

1.13 Subd. 7. Exemption. Nothing in this section modifies, supersedes, limits, or expands
1.14 the commissioner's authority to impose sanctions under section 256B.064.

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

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

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

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

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

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

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

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

2.4 (6) failure to repay an overpayment provided in section 256B.0641 or a fine finally
2.5 established under this section;

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

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

2.10 (b) For the purposes of this section, goods or services for which payment is made from
2.11 medical assistance includes but is not limited to care and services identified in section
2.12 256B.0625 or provided pursuant to any federally approved waiver.

2.13 (c) Regardless of the source of payment or other item of value, the commissioner may
2.14 impose sanctions against any individual or entity that solicits, receives, pays, or offers to
2.15 pay any illegal remuneration as described in section 142E.51, subdivision 6a, in violation
2.16 of section 609.542, subdivision 2, or in violation of United States Code, title 42, section
2.17 1320a-7b(b)(1) or (2). No conviction is required before the commissioner can impose
2.18 sanctions under this paragraph.

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

2.22 (e) The commissioner may impose sanctions against a pharmacy provider for failure to
2.23 respond to a Minnesota drug acquisition cost survey under section 256B.0625, subdivision
2.24 13e, paragraph (i).

2.25 (f) For the purposes of this section, "abuse" does not include billing errors that result in
2.26 unintended overcharges.

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

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

2.32 (1) suspending payments to an individual or entity under subdivision 2b;

3.1 (2) withholding payments to an individual or entity under subdivision 2b;

3.2 (3) suspending participation in the program under subdivision 2;

3.3 (4) terminating participation in the program under subdivision 2; or

3.4 (5) imposing a fine under subdivision 2a.

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

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

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

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

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

3.17 Subd. 1c. **Grounds for and methods of monetary recovery.** (a) The commissioner
 3.18 may obtain monetary recovery from an individual or entity ~~that has been improperly paid~~
 3.19 ~~by the department either as a result of conduct described in subdivision 1a or as a result of~~
 3.20 ~~an error by the individual or entity submitting the claim or by the department, regardless of~~
 3.21 ~~whether the error was intentional. Patterns need not be proven as a precondition to monetary~~
 3.22 ~~recovery of erroneous or false claims, duplicate claims, claims for services not medically~~
 3.23 ~~necessary, or claims based on false statements~~ for an overpayment as defined in Code of
 3.24 Federal Regulations, title 42, section 422.326.

3.25 (b) The commissioner may obtain monetary recovery using methods including but not
 3.26 limited to the following: assessing and recovering money improperly paid and debiting from
 3.27 future payments any money improperly paid. The commissioner ~~shall~~ must charge interest
 3.28 on money to be recovered if the recovery is to be made by installment payments or debits,
 3.29 except when the monetary recovery is of an overpayment that resulted from a department
 3.30 error. The interest charged ~~shall~~ must be the rate established by the commissioner of revenue
 3.31 under section 270C.40.

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

4.1 Sec. 6. Minnesota Statutes 2024, section 256B.064, subdivision 1d, is amended to read:

4.2 Subd. 1d. **Investigative costs.** (a) The commissioner may seek recovery of investigative
4.3 costs from any individual or entity that willfully submits a claim for reimbursement for
4.4 services that the individual or entity knows, or reasonably should have known, is a false
4.5 representation and that results in the payment of public funds for which the individual or
4.6 entity is ineligible violates the False Claims Act pursuant to United States Code, title 31,
4.7 section 3729-3733 or section 15C.02.

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

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

4.11 Sec. 7. Minnesota Statutes 2024, section 256B.064, subdivision 2, is amended to read:

4.12 Subd. 2. **Imposition of monetary recovery and sanctions; generally.** (a) The
4.13 commissioner ~~shall~~ must determine any monetary amounts to be recovered and sanctions
4.14 to be imposed upon an individual or entity under this section. ~~Except as provided in~~
4.15 ~~paragraphs (b) and (d), neither~~ The commissioner must not obtain a monetary recovery nor
4.16 or impose a sanction will be imposed by the commissioner without prior notice pursuant to
4.17 subdivision 4 and an opportunity for a hearing, according to chapter 14, on the
4.18 commissioner's proposed action, provided that the commissioner may suspend or reduce
4.19 payment to an individual or entity, except a nursing home or convalescent care facility, after
4.20 notice and prior to the hearing if in the commissioner's opinion that action is necessary to
4.21 protect the public welfare and the interests of the program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.17 (5) other information required by the commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.12 (1) a nursing home;

8.13 (2) a convalescing care facility;

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

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

8.18 (5) an entity providing customized living services as defined in section 256S.02,
8.19 subdivision 12.

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

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

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

8.28 Subd. 2d. **Imposition of monetary recovery and sanctions without prior notice.** (a)
8.29 Except as provided in subdivision 2c, when law enforcement requests that the commissioner
8.30 not suspend payments, or when the commissioner finds good cause not to suspend payments
8.31 under Code of Federal Regulations, title 42, section 455.23(e) or (f), the commissioner must

9.1 withhold or reduce payments to an individual or entity without providing advance notice
9.2 of the withholding or reduction if either of the following occurs:

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

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

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

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

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

9.22 (1) fraud hotline complaints;

9.23 (2) complaints from service recipients, guardians of service recipients, and case managers
9.24 of service recipients;

9.25 (3) claims data mining;

9.26 (4) patterns identified through provider audits, civil false claims cases, law enforcement
9.27 investigations, and investigations by other state or federal agencies; and

9.28 (5) court filings or other legal documents.

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

- 10.1 (1) state that payments are being withheld or reduced according to paragraph (a);
- 10.2 (2) set forth the allegations as to the nature of the withholding or reduction, which must
- 10.3 specify:
- 10.4 (i) each disputed item, and for each disputed item the reason for the dispute and an
- 10.5 estimate of the dollar amount involved;
- 10.6 (ii) the computation that the commissioner believes is correct;
- 10.7 (iii) the statute or rule the commissioner believes the individual or entity violated; and
- 10.8 (iv) other information necessary to aid the individual or entity when providing written
- 10.9 evidence under clause (5) or filing an appeal under section 256B.064, subdivision 2e;
- 10.10 (3) except in the case of a conviction for conduct described in subdivision 1a, state that
- 10.11 the withholding or reduction is for a temporary period not to exceed 60 days and cite the
- 10.12 circumstances under which withholding will be terminated;
- 10.13 (4) identify the types of claims to which the withholding or reduction applies; and
- 10.14 (5) inform the individual or entity of the right to submit written evidence for consideration
- 10.15 by the commissioner.
- 10.16 (f) The commissioner must acknowledge receipt of any written evidence submitted by
- 10.17 the individual or entity within five days of receipt of the written evidence. Within five days
- 10.18 of the commissioner's acknowledgment of receipt, the commissioner must (1) cease to
- 10.19 withhold or reduce payments, or (2) respond to the individual or entity with an explanation
- 10.20 of the commissioner's continued determination that there is sufficient evidence of fraud to
- 10.21 continue withholding or reducing payments.
- 10.22 (g) The commissioner must cease to withhold or reduce payments under this subdivision
- 10.23 after 60 days have passed, after the commissioner determines there is insufficient evidence
- 10.24 of fraud by the individual or entity, or after legal proceedings relating to the alleged fraud
- 10.25 are completed, unless the commissioner has sent notice of intention to impose monetary
- 10.26 recovery or sanctions.

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

10.28 Sec. 12. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision

10.29 to read:

10.30 Subd. 2e. **Appeal of suspended payments or withheld payments.** (a) Upon receipt of

10.31 a notice under subdivision 2d, paragraph (d), that a payment withhold is imposed, an

11.1 individual or entity may request a contested case, as defined in section 14.02, subdivision
11.2 3, by filing with the commissioner a written request of appeal. The appeal request must be
11.3 received by the commissioner no later than 30 days after the date the notification of the
11.4 payment withhold was mailed to the individual or entity. The appeal request must specify:

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

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

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

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

11.12 (5) other information required by the commissioner.

11.13 (b) Notwithstanding section 14.53, the cost of the contested case under this subdivision
11.14 must be paid by the individual or entity if the commissioner determines that the appeal was
11.15 frivolous, brought in bad faith, or without foundation.

11.16 (c) The commissioner shall have the burden of proof to establish by a preponderance of
11.17 the evidence that the allegations, facts, and evidence support a finding of a credible allegation
11.18 of fraud.

11.19 (d) The administrative law judge's findings of facts, conclusions of law, and
11.20 recommendation as to whether there is a credible allegation of fraud, may not be used or
11.21 considered for any other purpose, including impeachment, in any civil, criminal,
11.22 administrative, or contractual proceeding. The administrative law judge's findings of facts,
11.23 conclusions of law, and recommendation may not be held conclusive or binding or used as
11.24 evidence in any separate or subsequent action in any other forum, be it contractual,
11.25 administrative, or judicial, regardless of whether the action involves the same or related
11.26 parties or involves the same facts.

11.27 (e) If the commissioner believes there is good cause to do so to protect the integrity of
11.28 an ongoing investigation, the commissioner may submit evidence to support the action to
11.29 the administrative law judge under seal or require the administrative law judge to review
11.30 the evidence in camera without disclosure to individual or entity. The commissioner shall
11.31 not be subject to discovery by the individual or entity during the proceedings.

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

12.3 Subd. 2f. **Time-limited payment withhold.** (a) Notwithstanding any law to the contrary,
12.4 a temporary payment withhold pursuant to this section must be limited to an initial period
12.5 not to exceed 60 calendar days from the effective date of the withhold.

12.6 (b) Prior to the expiration of the initial 60-day period, the commissioner may seek an
12.7 extension of the payment withhold for an additional period of up to 60 days by submitting
12.8 a written request to an administrative law judge. The request must include evidence for in
12.9 camera review demonstrating that:

12.10 (1) a credible allegation of fraud continues to exist; and

12.11 (2) the commissioner is making reasonable efforts to investigate the allegation and to
12.12 pursue a permanent resolution through administrative, civil, or criminal proceedings.

12.13 (c) The administrative law judge shall review the commissioner's submission in camera
12.14 and, without a hearing, shall determine whether the requirements of paragraph (b) have
12.15 been satisfied. If the administrative law judge finds that the requirements have been met,
12.16 the judge shall authorize the extension. The judge's determination must be issued in writing.

12.17 (d) The commissioner may request no more than two extensions under this subdivision.
12.18 Each extension may not exceed 60 days. In no event shall a payment withhold under this
12.19 subdivision exceed a total duration of 180 days.

12.20 (e) If the commissioner does not obtain an extension under this subdivision prior to the
12.21 expiration of an existing withhold period, the commissioner shall immediately terminate
12.22 the payment withhold.

12.23 (f) Nothing in this subdivision limits the commissioner's authority to pursue recovery,
12.24 sanctions, or remedies under this section or other applicable law following the conclusion
12.25 of a payment withhold period.

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

12.28 Subd. 2g. **Good cause not to suspend.** (a) The commissioner may find that good cause
12.29 exists not to suspend payments, or not to continue a payment suspension previously imposed,
12.30 to an individual or entity against which there is an investigation of a credible allegation of
12.31 fraud if any of the following are applicable:

13.1 (1) law enforcement officials have specifically requested that a payment suspension not
13.2 be imposed because such a payment suspension may compromise or jeopardize an
13.3 investigation;

13.4 (2) other available remedies implemented by the commissioner more effectively or
13.5 quickly protect medical assistance funds;

13.6 (3) the commissioner determines, based upon the submission of written evidence by the
13.7 individual or entity that is the subject of the payment suspension, that the suspension should
13.8 be removed;

13.9 (4) beneficiary access to items or services would be jeopardized by a payment suspension
13.10 because of either of the following:

13.11 (i) an individual or entity is the sole community physician or the sole source of essential
13.12 specialized services in a community;

13.13 (ii) the individual or entity serves a large number of beneficiaries within a
13.14 HRSA-designated medically underserved area; or

13.15 (iii) the individual or entity operates a provider-controlled residential setting for which
13.16 individuals are reliant on the individual or entity for services;

13.17 (5) law enforcement declines to certify that a matter continues to be under investigation
13.18 per the requirements of Code of Federal Regulations, title 42, section 455.23(d)(3); or

13.19 (6) the commissioner determines that payment suspension is not in the best interests of
13.20 the medical assistance program.

13.21 (b) The commissioner may find that good cause exists to suspend payments in part, or
13.22 to convert a payment suspension previously imposed in whole to one only in part, to an
13.23 individual or entity against which there is an investigation of a credible allegation of fraud
13.24 if any of the following are applicable:

13.25 (1) beneficiary access to items or services would be jeopardized by a payment suspension
13.26 in whole or part because of either of the following:

13.27 (i) an individual or entity is the sole community physician or the sole source of essential
13.28 specialized services in a community;

13.29 (ii) the individual or entity serves a large number of beneficiaries within a
13.30 HRSA-designated medically underserved area; or

13.31 (iii) the individual or entity operates a provider-controlled residential setting for which
13.32 individuals are reliant on the individual or entity for services;

14.1 (2) the commissioner determines, based upon the submission of written evidence by the
14.2 individual or entity that is the subject of a whole payment suspension, that such suspension
14.3 should be imposed only in part;

14.4 (3) the credible allegation focuses solely and definitively on only a specific type of claim
14.5 or arises from only a specific business unit of a provider, and the commissioner determines
14.6 and documents in writing that a payment suspension in part would effectively ensure that
14.7 potentially fraudulent claims were not continuing to be paid;

14.8 (4) law enforcement declines to certify that a matter continues to be under investigation
14.9 per the requirements of Code of Federal Regulations, title 42, section 455.23(d)(3); or

14.10 (5) the commissioner determines that payment suspension only in part is in the best
14.11 interests of the medical assistance program.

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

14.14 Subd. 2h. **Forfeiture of withheld payments upon criminal conviction.** Upon conviction
14.15 for a crime related to the provision, management, or administration of a health service under
14.16 medical assistance, a payment held pursuant to this section by the commissioner or a managed
14.17 care organization that contracts with the commissioner under section 256B.035 is forfeited
14.18 to the commissioner or managed care organization, regardless of the amount charged in the
14.19 criminal complaint or the amount of criminal restitution ordered.

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

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

14.22 Subd. 3. **Mandates on prohibited payments.** (a) The commissioner ~~shall~~ must maintain
14.23 and publish a list of each excluded individual and entity that was convicted of a crime related
14.24 to the provision, management, or administration of a medical assistance health service, or
14.25 suspended or terminated under ~~subdivision 2~~ this section. Medical assistance payments
14.26 cannot be made by an individual or entity for items or services furnished either directly or
14.27 indirectly by an excluded individual or entity, or at the direction of excluded individuals or
14.28 entities.

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

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

15.5 (d) An entity that pays medical assistance program funds to an individual or entity on
15.6 the exclusion list must refund any payment related to ~~either~~ items or and services rendered
15.7 by an individual or entity on the exclusion list from the date the individual or entity is first
15.8 paid or the date the individual or entity is placed on the exclusion list, whichever is later,
15.9 and an entity may be subject to:

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

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

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

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

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

15.17 Subd. 4. **Notice.** (a) The department ~~shall~~ must serve the notice required under ~~subdivision~~
15.18 2 this section using a signature-verified confirmed delivery method to the address submitted
15.19 to the department by the individual or entity. Service is complete upon mailing.

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

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

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

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

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

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

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

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

16.16 Sec. 19. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
16.17 to read:

16.18 **Subd. 6. Application.** This section supersedes any inconsistent or contrary provision of
16.19 law.

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

16.21 Sec. 20. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; MEDICAL**
16.22 **ASSISTANCE PROGRAM INTEGRITY ADVISORY BOARD.**

16.23 **(a) By January 1, 2027, the commissioner of human services must establish a medical**
16.24 **assistance program integrity advisory board. The board must oversee medical assistance**
16.25 **program integrity efforts, evaluate the efforts, and provide recommendations, including but**
16.26 **not limited to legislative changes, to the commissioner on ways to improve medical assistance**
16.27 **program integrity. The board must advise the commissioner on enforcement proportionality,**
16.28 **analytics governance, and program integrity metrics.**

16.29 **(b) The board must consist of seven members appointed by the commissioner of human**
16.30 **services and must include:**

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

- 17.1 (2) at least one member who is a data scientist;
17.2 (3) at least one member who is a long-term services and supports program expert;
17.3 (4) at least one member who is a program design and evaluation specialist; and
17.4 (5) at least one member of the public.

17.5 (c) The commissioner must annually select a board chair from among the members. The
17.6 commissioner must comply with Minnesota Statutes, section 15.059.

17.7 **Sec. 21. DIRECTION TO COMMISSIONER OF HUMAN SERVICES; MEDICAL**
17.8 **ASSISTANCE PROVIDER ENROLLMENT STANDARDS.**

17.9 (a) By January 1, 2027, the commissioner of human services must make recommendations
17.10 to the chairs and ranking minority members of the legislative committees with jurisdiction
17.11 over human services policy and finance regarding statutory and program changes to ensure
17.12 only qualified, prepared, and financially stable providers are permitted to enroll as a medical
17.13 assistance provider type designated by the commissioner as high-risk under Minnesota
17.14 Statutes, section 256B.044, subdivision 1.

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

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

17.22 **Sec. 22. DIRECTION TO COMMISSIONER OF HUMAN SERVICES; PROGRAM**
17.23 **INTEGRITY TECHNOLOGY MODERNIZATION.**

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

18.1 Sec. 23. 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 Sec. 24. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES;**
19.2 **PROPORTIONAL MEDICAL ASSISTANCE PROGRAM INTEGRITY**
19.3 **INTERVENTIONS.**

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

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

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

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

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

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

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

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

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

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

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

19.28 Sec. 25. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
19.29 **CODIFYING THE OFFICE OF THE INSPECTOR GENERAL.**

19.30 (a) By December 1, 2026, the commissioner of human services must provide statutory
19.31 language that codifies the Department of Human Services Office of the Inspector General

20.1 to the chairs and ranking minority members of the legislative committees with jurisdiction
 20.2 over human services and the nonpartisan staff from House Research Department and Senate
 20.3 Counsel, Research, and Fiscal Analysis whose drafting areas include human services. The
 20.4 statutory language must only contain:

20.5 (1) existing legal authority identified by the office that the office relies upon to carry
 20.6 out its duties; and

20.7 (2) policies and procedures necessary for the office to carry out its existing duties.

20.8 (b) The commissioner must not include desired policy changes to the office, its structure,
 20.9 or its duties within the codification language required under paragraph (a).

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

20.11 **ARTICLE 2**

20.12 **MEDICAL ASSISTANCE PROVIDER ENROLLMENT MODIFICATIONS**

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

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

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

20.19 (2) the individual designated as the authorized agent under section 142B.10, subdivision
 20.20 1, paragraph (b);

20.21 (3) the individual designated as the compliance officer under section ~~256B.04, subdivision~~
 20.22 ~~21, paragraph (g)~~ 256B.044, subdivision 7, paragraph (b);

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

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

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

20.28 (b) Controlling individual does not include:

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

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

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

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

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

21.13 (4) an individual who is a member of an organization exempt from taxation under section
21.14 290.05, unless the individual is also an officer, owner, or managerial official of the program
21.15 or owns any of the beneficial interests not excluded in this subdivision. This clause does
21.16 not exclude from the definition of controlling individual an organization that is exempt from
21.17 taxation; or

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

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

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

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

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

22.1 (2) the individual designated as the authorized agent under section 245A.04, subdivision
22.2 1, paragraph (b);

22.3 (3) the individual designated as the compliance officer under section ~~256B.04, subdivision~~
22.4 ~~21, paragraph (g)~~ 256B.044, subdivision 7, paragraph (b);

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

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

22.8 (b) Controlling individual does not include:

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

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

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

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

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

22.21 (4) an individual who is a member of an organization exempt from taxation under section
22.22 290.05, unless the individual is also an officer, owner, or managerial official of the program
22.23 or owns any of the beneficial interests not excluded in this subdivision. This clause does
22.24 not exclude from the definition of controlling individual an organization that is exempt from
22.25 taxation; or

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

22.29 (c) For purposes of this subdivision, "managerial official" means an individual who has
22.30 the decision-making authority related to the operation of the program, and the responsibility
22.31 for the ongoing management of or direction of the policies, services, or employees of the

23.1 program. A site director who has no ownership interest in the program is not considered to
23.2 be a managerial official for purposes of this definition.

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

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

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

23.22 When the commissioner receives an application for initial licensure that is incomplete
23.23 because the applicant failed to submit required documents or that is substantially deficient
23.24 because the documents submitted do not meet licensing requirements, the commissioner
23.25 shall provide the applicant written notice that the application is incomplete or substantially
23.26 deficient. In the written notice to the applicant the commissioner shall identify documents
23.27 that are missing or deficient and give the applicant 45 days to resubmit a second application
23.28 that is substantially complete. An applicant's failure to submit a substantially complete
23.29 application after receiving notice from the commissioner is a basis for license denial under
23.30 section 245A.043.

23.31 (b) An application for licensure must identify all controlling individuals as defined in
23.32 section 245A.02, subdivision 5a, and must designate one individual to be the authorized
23.33 agent. The application must be signed by the authorized agent and must include the authorized
23.34 agent's first, middle, and last name; mailing address; and email address. By submitting an

24.1 application for licensure, the authorized agent consents to electronic communication with
24.2 the commissioner throughout the application process. The authorized agent must be
24.3 authorized to accept service on behalf of all of the controlling individuals. A government
24.4 entity that holds multiple licenses under this chapter may designate one authorized agent
24.5 for all licenses issued under this chapter or may designate a different authorized agent for
24.6 each license. Service on the authorized agent is service on all of the controlling individuals.
24.7 It is not a defense to any action arising under this chapter that service was not made on each
24.8 controlling individual. The designation of a controlling individual as the authorized agent
24.9 under this paragraph does not affect the legal responsibility of any other controlling individual
24.10 under this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

25.13 (3) the first, middle, and last name, and address for all individuals who will be controlling
25.14 individuals, including all officers, owners, and managerial officials as defined in section
25.15 245A.02, subdivision 5a, and the date that the background study was initiated by the applicant
25.16 for each controlling individual;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26.26 (1) the application;

26.27 (2) the renewal;

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

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

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

27.1 The attestation must include the name and business contact information of the business or
27.2 consultant that assisted.

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

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

27.9 (1) the name of the license holder;

27.10 (2) the address of the program;

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

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

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

27.14 and

27.15 (6) any special conditions of licensure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

28.25 (h) The commissioner shall not issue or reissue a license under this chapter if an individual
28.26 living in the household where the services will be provided as specified under section
28.27 245C.03, subdivision 1, has been disqualified and the disqualification has not been set aside
28.28 and no variance has been granted.

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

29.1 (j) Notwithstanding paragraph (i), when a revocation is based on the disqualification of
29.2 a controlling individual or license holder, and the controlling individual or license holder
29.3 is ordered under section 245C.17 to be immediately removed from direct contact with
29.4 persons receiving services or is ordered to be under continuous, direct supervision when
29.5 providing direct contact services, the program may continue to operate only if the program
29.6 complies with the order and submits documentation demonstrating compliance with the
29.7 order. If the disqualified individual fails to submit a timely request for reconsideration, or
29.8 if the disqualification is not set aside and no variance is granted, the order to immediately
29.9 remove the individual from direct contact or to be under continuous, direct supervision
29.10 remains in effect pending the outcome of a hearing and final order from the commissioner.

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

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

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

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

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

29.28 **245A.05 DENIAL OF APPLICATION.**

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

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

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

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

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

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

30.9 (6) is associated with an individual who received a background study under section
30.10 245C.03, subdivision 1, paragraph (a), clause (6), who may have unsupervised access to
30.11 children or vulnerable adults, and who has a disqualification that has not been set aside
30.12 under section 245C.22, and no variance has been granted;

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

30.14 (8) fails to demonstrate competent knowledge as required by section 245A.04, subdivision
30.15 6;

30.16 (9) has a history of noncompliance as a license holder or controlling individual with
30.17 applicable laws or rules, including but not limited to this chapter and chapters 142E and
30.18 245C;

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

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

30.21 (b) An applicant whose application has been denied by the commissioner must be given
30.22 notice of the denial, which must state the reasons for the denial in plain language. Notice
30.23 must be given by certified mail, by personal service, or through the provider licensing and
30.24 reporting hub. The notice must state the reasons the application was denied and must inform
30.25 the applicant of the right to a contested case hearing under chapter 14 and Minnesota Rules,
30.26 parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the
30.27 commissioner in writing by certified mail, by personal service, or through the provider
30.28 licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the
30.29 commissioner within 20 calendar days after the applicant received the notice of denial. If
30.30 an appeal request is made by personal service, it must be received by the commissioner
30.31 within 20 calendar days after the applicant received the notice of denial. If the order is issued
30.32 through the provider hub, the appeal must be received by the commissioner within 20

31.1 calendar days from the date the commissioner issued the order through the hub. Section
31.2 245A.08 applies to hearings held to appeal the commissioner's denial of an application.

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

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

31.8 (1) maintaining a current understanding of the licensing requirements sufficient to ensure
31.9 compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph
31.10 (e), and when applicable, as identified in section ~~256B.04, subdivision 21, paragraph (g)~~
31.11 256B.044, subdivision 7;

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

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

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

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

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

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

31.30 (b) The designated manager must be competent to perform the duties as required and
31.31 must minimally meet the education and training requirements identified in subdivision 2,

32.1 paragraph (b), and have a minimum of three years of supervisory level experience in a
32.2 program that provides care or education to vulnerable adults or children.

32.3 Sec. 7. Minnesota Statutes 2024, section 256B.04, subdivision 5, is amended to read:

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

32.11 Sec. 8. Minnesota Statutes 2025 Supplement, section 256B.04, subdivision 21, is amended
32.12 to read:

32.13 Subd. 21. **Provider enrollment.** ~~(a)~~ The commissioner shall enroll providers and conduct
32.14 screening activities as required by Code of Federal Regulations, title 42, section 455, subpart
32.15 E, and sections 256B.044 to 256B.0446.

32.16 ~~A provider must enroll each provider-controlled location where direct services are~~
32.17 ~~provided. The commissioner may deny a provider's incomplete application if a provider~~
32.18 ~~fails to respond to the commissioner's request for additional information within 60 days of~~
32.19 ~~the request. The commissioner must conduct a background study under chapter 245C,~~
32.20 ~~including a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses~~
32.21 ~~(1) to (5), for a provider described in this paragraph. The background study requirement~~
32.22 ~~may be satisfied if the commissioner conducted a fingerprint-based background study on~~
32.23 ~~the provider that includes a review of databases in section 245C.08, subdivision 1, paragraph~~
32.24 ~~(a), clauses (1) to (5).~~

32.25 (b) The commissioner shall revalidate:

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

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

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

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

33.1 ~~(e) The commissioner shall conduct revalidation as follows:~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

34.30 ~~(j) As a condition of enrollment in medical assistance, the commissioner shall require~~
34.31 ~~that a provider designated "moderate" or "high-risk" by the Centers for Medicare and~~
34.32 ~~Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid~~
34.33 ~~Services, its agents, or its designated contractors and the state agency, its agents, or its~~

35.1 ~~designated contractors to conduct unannounced on-site inspections of any provider location.~~
35.2 ~~The commissioner shall publish in the Minnesota Health Care Program Provider Manual a~~
35.3 ~~list of provider types designated "limited," "moderate," or "high-risk," based on the criteria~~
35.4 ~~and standards used to designate Medicare providers in Code of Federal Regulations, title~~
35.5 ~~42, section 424.518. The list and criteria are not subject to the requirements of chapter 14.~~
35.6 ~~The commissioner's designations are not subject to administrative appeal.~~

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

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

35.22 ~~(2) At the time of initial enrollment or reenrollment, durable medical equipment providers~~
35.23 ~~and suppliers defined in clause (3) 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 ~~(3) "Durable medical equipment provider or supplier" means a medical supplier that can~~
35.33 ~~purchase medical equipment or supplies for sale or rental to the general public and is able~~
35.34 ~~to perform or arrange for necessary repairs to and maintenance of equipment offered for~~
35.35 ~~sale or rental.~~

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

36.13 Sec. 9. **[256B.044] PROVIDER ENROLLMENT.**

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

36.19 (b) The list and criteria are not subject to the requirements of chapter 14, and section
36.20 14.386 does not apply.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

37.25 (f) A provider's enrollment must be denied or terminated if a provider or individual
37.26 subject to a background study under this subdivision is either disqualified under chapter
37.27 245C and has not received a set-aside of the disqualification or is excluded from participating
37.28 in any federal health care programs.

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

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

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

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

38.9 Subd. 5. Site visits. (a) As a condition of enrollment in medical assistance, the
38.10 commissioner shall require that a provider permit the Centers for Medicare and Medicaid
38.11 Services (CMS), CMS's agents, or CMS's designated contractors and the Department of
38.12 Human Services (DHS), DHS's agents, or DHS's designated contractors to conduct
38.13 unannounced site visits of any of a provider's enrolled locations.

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

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

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

38.20 (3) unannounced site visits, as follows:

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

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

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

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

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

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

39.1 (1) the provider fails to demonstrate financial viability;
39.2 (2) the commissioner determines there is significant evidence of or potential for fraud
39.3 and abuse by the provider; or

39.4 (3) the provider or category of providers is designated high-risk pursuant to subdivision
39.5 1.

39.6 (b) The surety bond must be in an amount of \$100,000 or five percent of the provider's
39.7 payments for medical assistance services designated as high-risk during the immediately
39.8 preceding 12 months, whichever is greater. The surety bond must name DHS as an obligee
39.9 and must allow for recovery of costs and fees in pursuing a claim on the bond. Nothing in
39.10 this subdivision prohibits a provider from meeting its surety bond requirement through
39.11 participation in a self-insurance cooperative, other pooled risk arrangement, or other
39.12 equivalent insurance products that name DHS as an obligee.

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

39.15 Subd. 7. **Compliance programs.** (a) The commissioner may require, as a condition of
39.16 enrollment in medical assistance, that a provider in a particular industry, of a particular
39.17 provider type, or with a particular risk categorization under subdivision 1, establish and
39.18 maintain a compliance program consistent with federal program integrity guidance issued
39.19 by CMS or the United States Department of Health and Human Services Office of Inspector
39.20 General.

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

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

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

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

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

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

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

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

40.6 Subd. 8. **Incomplete provider enrollment applications.** The commissioner must deny
40.7 a provider's incomplete enrollment application if a provider fails to respond to the
40.8 commissioner's request for additional information within 60 days of the request.

40.9 Subd. 9. **Correspondence and notification.** The commissioner must deliver
40.10 correspondence and notifications, including notifications of termination and other actions,
40.11 electronically to a provider's MN-ITS mailbox. This subdivision does not apply to
40.12 correspondences and notifications related to background studies.

40.13 Sec. 10. **[256B.0441] PROVIDER REVALIDATION.**

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

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

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

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

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

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

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

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

40.27 (1) provide 30 days notice to the provider of the provider's revalidation due date, including
40.28 instructions for revalidation, a list of materials the provider must submit, and a notice about
40.29 the unannounced site visit required under paragraph (b);

40.30 (2) if a provider fails to submit all required materials or satisfy the requirements of
40.31 paragraph (b) by the due date, notify the provider of the deficiency within 30 days after the

41.1 due date and allow the provider an additional 30 days from the notification date to comply;
41.2 and

41.3 (3) if a provider fails to remedy a deficiency within the additional 30-day time period,
41.4 give 60 days notice of termination and immediately suspend the provider's ability to bill.

41.5 The commissioner's decision to suspend the provider's ability to bill is subject to an
41.6 administrative appeal.

41.7 (b) The commissioner must conduct unannounced site visits at each of a provider's
41.8 enrolled locations under section 256B.044, subdivision 5, no more than 30 days prior to the
41.9 provider's revalidation due date.

41.10 **Sec. 11. [256B.0442] PROVIDER ENROLLMENT SUSPENSIONS AND**
41.11 **TERMINATIONS.**

41.12 Subdivision 1. **Suspension of billing privileges.** (a) If a provider fails to comply with
41.13 any individual provider requirement or condition of participation, the commissioner may
41.14 suspend the provider's ability to bill until the provider comes into compliance. The
41.15 commissioner must respond to a provider's submission of proof of compliance within five
41.16 business days of receipt of the provider's submission.

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

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

41.22 (d) The commissioner's decision to suspend a provider's ability to bill is subject to an
41.23 administrative appeal.

41.24 Subd. 2. **Suspension for lack of documentation.** (a) The commissioner may suspend
41.25 the enrollment of an ordering or rendering provider for a period of not more than one year
41.26 if the provider fails to:

41.27 (1) maintain according to professional community standards documentation of orders
41.28 or requests for payment for durable medical equipment, certifications for home health
41.29 services, or referrals for other items or services; or

41.30 (2) provide, upon request from the commissioner, access to documentation specified in
41.31 clause (1).

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

42.3 Subd. 3. **Authority to deny or terminate enrollment.** The commissioner may terminate
42.4 or deny the enrollment of a provider when:

42.5 (1) an individual with a five percent or greater direct or indirect ownership interest in
42.6 the provider does not submit timely and accurate information;

42.7 (2) the provider, or an individual with an ownership or control interest or who is an agent
42.8 or managing employee of the provider, fails to submit timely or accurate information, unless
42.9 the commissioner determines that termination or denial of enrollment is not in the best
42.10 interests of the medical assistance program and the commissioner documents that
42.11 determination in writing; or

42.12 (3) the provider, or an individual with a five percent or greater direct or indirect ownership
42.13 interest in the provider, fails to submit sets of fingerprints in a form and manner determined
42.14 by the commissioner within 30 days of a request from the Centers for Medicare and Medicaid
42.15 Services (CMS) or the commissioner, unless the commissioner determines that termination
42.16 or denial of enrollment is not in the best interests of the medical assistance program and the
42.17 commissioner documents that determination in writing.

42.18 Subd. 4. **Mandatory denial or termination of enrollment.** (a) The commissioner must
42.19 terminate or deny the enrollment of a provider when:

42.20 (1) an individual with a five percent or greater direct or indirect ownership interest in
42.21 the provider has been convicted of a criminal offense related to the individual's involvement
42.22 in Medicare, Medicaid, or the Children's Health Insurance Program in the last ten years,
42.23 unless the commissioner determines that denial or termination of enrollment is not in the
42.24 best interests of the medical assistance program and the commissioner documents that
42.25 determination in writing;

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

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

43.1 (4) CMS or the commissioner determines that the provider has intentionally falsified
43.2 any information provided on the application or cannot verify the identity of any provider
43.3 applicant.

43.4 (b) The commissioner may exempt a rehabilitation agency from termination or denial
43.5 that would otherwise be required under paragraph (a), clause (2), if the agency:

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

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

43.10 (3) serves primarily a pediatric population.

43.11 **Sec. 12. [256B.0443] PROVIDER PAYMENT WITHHOLDS.**

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

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

43.18 **Sec. 13. [256B.0444] ENROLLMENT MORATORIUM FOR HIGH-RISK**
43.19 **PROVIDERS.**

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

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

43.30 Subd. 3. **Notice.** At least ten days prior to issuing an enrollment moratorium under this
43.31 section, the commissioner must notify the chairs and ranking minority members of the

44.1 legislative committees with jurisdiction over health and human services policy and finance
44.2 about the actions the commissioner plans to take under this section. The notice must:

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

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

44.5 (3) identify the start date and anticipated duration of the enrollment moratorium.

44.6 Subd. 4. **Report to legislature.** Within 60 days of ending an enrollment moratorium
44.7 under this section, the commissioner must submit a report to the chairs and ranking minority
44.8 members of the legislative committees with jurisdiction over health and human services
44.9 policy and finance. The report must include, at a minimum:

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

44.12 (2) recommendations for modifying or terminating the covered services delivered by
44.13 provider types subject to the moratorium.

44.14 Sec. 14. **[256B.0445] ADDITIONAL PROVIDER ENROLLMENT REQUIREMENTS**
44.15 **FOR HIGH-RISK PROVIDERS.**

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

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

44.28 (b) New owners active in day-to-day management and operations of the agency and new
44.29 managerial and supervisory employees of the agency must complete compliance training
44.30 under this subdivision within 30 calendar days of becoming an owner of or employed by
44.31 the agency and prior to conducting any management and operations activities for the agency.
44.32 If an individual moves to another agency providing the same service and serves in a similar

45.1 ownership or employment capacity, the individual is not required to repeat the training
45.2 required under this subdivision. If the individual chooses not to repeat the compliance
45.3 training, the individual must provide the agency with documentation proving the individual
45.4 completed the compliance training within the provider revalidation schedule for the relevant
45.5 provider type as determined by the commissioner under section 256B.0441.

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

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

45.10 (2) enrollment requirements;

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

45.12 (4) fair labor standards;

45.13 (5) workplace safety requirements; and

45.14 (6) recent changes in service requirements.

45.15 **Sec. 15. [256B.0446] ADDITIONAL PROVIDER ENROLLMENT REQUIREMENTS**
45.16 **FOR SPECIFIC PROVIDER TYPES.**

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

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

45.30 (c) At the time of initial enrollment or reenrollment, durable medical equipment providers
45.31 or suppliers defined in paragraph (a) must purchase a surety bond of \$50,000. If a revalidating
45.32 provider's Medicaid revenue in the previous calendar year is up to and including \$300,000,

46.1 the provider agency must purchase a surety bond of \$50,000. If a revalidating provider's
46.2 Medicaid revenue in the previous calendar year is over \$300,000, the provider agency must
46.3 purchase a surety bond of \$100,000. The surety bond must allow for recovery of costs and
46.4 fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions
46.5 from a surety bond must occur within six years from the date the debt is affirmed by a final
46.6 agency decision. An agency decision is final when the right to appeal the debt has been
46.7 exhausted or the time to appeal has expired under section 256B.064.

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

46.12 Subd. 3. **Providers licensed by the commissioner of health.** An enrolled provider that
46.13 is licensed by the commissioner of health as a home care provider under chapter 144A with
46.14 a home and community-based services designation under section 144A.484 on the home
46.15 care license, or as an assisted living facility under chapter 144G, must designate an individual
46.16 as the licensee's compliance officer under section 256B.044, subdivision 7, paragraph (b).

46.17 Sec. 16. Minnesota Statutes 2025 Supplement, section 256B.0759, subdivision 4, is
46.18 amended to read:

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

46.33 (b) The commissioner may temporarily suspend payments to the provider according to
46.34 section ~~256B.04, subdivision 21, paragraph (d)~~ 256B.0442, subdivision 1, if the provider

47.1 does not meet the requirements in paragraph (a). Payments withheld from the provider must
47.2 be made once the commissioner determines that the requirements in paragraph (a) are met.

47.3 (c) For outpatient individual and group substance use disorder services under section
47.4 254B.0505, subdivision 1, clause (1), and adolescent treatment programs that are licensed
47.5 as outpatient treatment programs according to sections 245G.01 to 245G.18, provided on
47.6 or after January 1, 2021, payment rates must be increased by 20 percent over the rates in
47.7 effect on December 31, 2020.

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

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

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

47.29 Sec. 17. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 16, is
47.30 amended to read:

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

48.1 (1) enroll as a medical assistance Minnesota health care program provider according to
48.2 Minnesota Rules, part 9505.0195, and ~~section 256B.04, subdivision 21~~ sections 256B.044
48.3 to 256B.0446, and meet all applicable provider standards and requirements;

48.4 (2) designate an individual as the agency's compliance officer who must perform the
48.5 duties described in section ~~256B.04, subdivision 21, paragraph (g)~~ 256B.044, subdivision
48.6 7, paragraph (b);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

49.13 (16) provide required EIDBI intervention observation and direction at least once per
49.14 month. Notwithstanding subdivision 13, paragraph (l), required EIDBI intervention
49.15 observation and direction under this clause may be conducted via telehealth provided that
49.16 no more than two consecutive monthly required EIDBI intervention observation and direction
49.17 sessions under this clause are conducted via telehealth.

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

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

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

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

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

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

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

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

50.4 Sec. 18. Minnesota Statutes 2024, section 256B.0949, subdivision 17, is amended to read:

50.5 Subd. 17. **Provider shortage; authority for exceptions.** (a) In consultation with the
50.6 Early Intensive Developmental and Behavioral Intervention Advisory Council and
50.7 stakeholders, including agencies, professionals, parents of people with ASD or a related
50.8 condition, and advocacy organizations, the commissioner shall determine if a shortage of
50.9 EIDBI providers exists. For the purposes of this subdivision, "shortage of EIDBI providers"
50.10 means a lack of availability of providers who meet the EIDBI provider qualification
50.11 requirements under subdivision 15 that results in the delay of access to timely services under
50.12 this section, or that significantly impairs the ability of a provider agency to have sufficient
50.13 providers to meet the requirements of this section. The commissioner shall consider
50.14 geographic factors when determining the prevalence of a shortage. The commissioner may
50.15 determine that a shortage exists only in a specific region of the state, multiple regions of
50.16 the state, or statewide. The commissioner shall also consider the availability of various types
50.17 of treatment modalities covered under this section.

50.18 (b) The commissioner, in consultation with the Early Intensive Developmental and
50.19 Behavioral Intervention Advisory Council and stakeholders, must establish processes and
50.20 criteria for granting an exception under this paragraph. The commissioner may grant an
50.21 exception only if the exception would not compromise a person's safety and not diminish
50.22 the effectiveness of the treatment. The commissioner may establish an expiration date for
50.23 an exception granted under this paragraph. The commissioner may grant an exception for
50.24 the following:

50.25 (1) EIDBI provider qualifications under this section;

50.26 (2) medical assistance provider enrollment requirements under ~~section 256B.04,~~
50.27 ~~subdivision 21~~ sections 256B.044 to 256B.0446; or

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

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

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

51.5 **Sec. 19. DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES.**

51.6 The commissioner of human services must amend Minnesota Rules, part 9505.2165,
 51.7 subpart 4, item C, to remove the citation to United States Code, title 42, section
 51.8 1320a-7b(b)(3)(D), and insert a citation to United States Code, title 42, section 1320a-7b(b).
 51.9 The commissioner may use the procedure under Minnesota Statutes, section 14.388,
 51.10 subdivision 1, clause (3), for changes to Minnesota Rules pursuant to this section. Minnesota
 51.11 Statutes, section 14.386, does not apply to rules adopted pursuant to this section except as
 51.12 provided under Minnesota Statutes, section 14.388.

51.13 **Sec. 20. MANDATORY COMPLIANCE TRAINING FOR CURRENTLY**
 51.14 **ENROLLED HIGH-RISK MEDICAL ASSISTANCE PROVIDERS.**

51.15 The owners and employees of any medical assistance provider agency subject to the
 51.16 requirements of Minnesota Statutes, section 256B.0445, subdivision 2, and enrolled before
 51.17 January 1, 2027, must complete initial compliance training by January 1, 2028. Owners and
 51.18 employees of PCA and CFSS agencies who enrolled before January 1, 2027, and have
 51.19 previously completed training under Minnesota Statutes, section 256B.0659, subdivision
 51.20 21, paragraph (c), or 256B.85, subdivision 12, paragraph (c), are not subject to the initial
 51.21 training requirements of this section but must repeat the compliance training prior to
 51.22 revalidation as a medical assistance provider.

51.23 **Sec. 21. REPEALER.**

51.24 Minnesota Statutes 2025 Supplement, sections 256B.051, subdivision 6b; and 256B.0701,
 51.25 subdivision 11, are repealed."

51.26 Delete the title and insert:

51.27 "A bill for an act
 51.28 relating to human services; modifying requirements for provider enrollment in
 51.29 medical assistance; modifying program integrity requirements for the medical
 51.30 assistance program; directing the commissioner of human services to create a
 51.31 medical assistance program integrity advisory board; directing the commissioner
 51.32 of human services to make recommendations on provider enrollment standards,
 51.33 modernizing program integrity infrastructure, and program integrity interventions;
 51.34 directing the commissioner of human services to conduct audits; requiring reports;
 51.35 making technical changes; authorizing rulemaking; appropriating money; amending

52.1 Minnesota Statutes 2024, sections 142B.01, subdivision 8; 245.095, by adding a
52.2 subdivision; 245A.02, subdivision 5a; 245D.081, subdivision 3; 256B.04,
52.3 subdivision 5; 256B.064, subdivisions 1b, 1c, 1d, 2, 3, 4, 5, by adding subdivisions;
52.4 256B.0949, subdivision 17; Minnesota Statutes 2025 Supplement, sections 15.013,
52.5 by adding a subdivision; 245A.04, subdivisions 1, 7; 245A.05; 256B.04, subdivision
52.6 21; 256B.064, subdivision 1a; 256B.0759, subdivision 4; 256B.0949, subdivision
52.7 16; proposing coding for new law in Minnesota Statutes, chapter 256B; repealing
52.8 Minnesota Statutes 2025 Supplement, sections 256B.051, subdivision 6b;
52.9 256B.0701, subdivision 11."