

**Subject** Department of Human Services Finance Bill

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### **Overview**

This bill contains the Department of Human Services supplemental budget, including provisions related to health care, Office of Inspector General policy, background studies, behavioral health, uniform service standards, aging and disability services, miscellaneous provisions, and appropriations.

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## Article 1: Health Care

This article makes changes to the requirements governing health care provider enrollment in medical assistance (MA), establishes prepayment and postpayment review of MA claims, and allows the commissioner of the Department of Human Services (DHS) to establish MA provider enrollment moratoria in specified circumstances. The article also reorganizes the statute governing MA sanctions, clarifies the applicability of related statutes, adds sections allowing for administrative review of temporary payment withholding or reduction actions, and adds required compliance training for high-risk MA provider types. Finally, the article provides for MA recipient protections, continuity of care, and transition payments under certain circumstances.

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- 1      **Exemption.**  
Amends § 15.013 by adding subd. 7. Clarifies that nothing in the section governing payment withholds modifies, supersedes, limits, or expands the authority of the commissioner of human services to impose sanctions under section 256B.064.
  
- 2      **Controlling individual.**  
Amends § 142B.01, subd. 8. Updates a cross-reference related to the recodification of section 256B.04, subdivision 21.
  
- 3      **Exemption.**  
Amends § 245.095 by adding subd. 7. Clarifies that nothing in section 245.095 modifies, supersedes, limits, or expands the commissioner's authority to impose medical assistance sanctions under section 256B.064.
  
- 4      **Controlling individual.**  
Amends § 245A.02, subd. 5a. Updates a cross-reference related to the recodification of section 256B.04, subdivision 21.
  
- 5      **Application for licensure.**  
Amends § 245A.04, subd. 1. Adds paragraph (j), requiring any applicant or license holder that elects to receive publicly funded reimbursement for providing services designated as high-risk to provide an attestation stating whether the applicant or authorized agent received third-party assistance with preparing the application or renewal, or any related documentation.
  
- 6      **Grant of license; license extension.**  
Amends § 245A.04, subd. 7. Makes technical conforming change.

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**7 Denial of application.**

Amends § 245A.05. Makes technical conforming change.

**8 Program management and oversight.**

Amends § 245D.081, subd. 3. Updates a cross-reference related to the recodification of section 256B.04, subdivision 21.

**9 Annual report required.**

Amends § 256B.04, subd. 5. Provides that DHS must include, in its annual report on the MA program, a full account of all pre-enrollment, postenrollment, and unannounced site visits to MA providers in the previous fiscal year.

**10 Provider enrollment.**

Amends § 256B.04, subd. 21. Strikes the requirements related to MA provider enrollment. Under this bill, the requirements are recodified in new sections of state statutes, as follows:

- Paragraph (a): Recodified in § 256B.044, subds. 3, 4, and 9
- Paragraph (b): Recodified in § 256B.0441, subd. 2
- Paragraph (c): Recodified in § 256B.0441, subd. 3
- Paragraph (d): Recodified in § 256B.0442, subd. 1
- Paragraph (e): Recodified in § 256B.044, subd. 10
- Paragraph (f): Recodified in § 256B.0433
- Paragraph (g): Recodified in §§ 256B.044, subd. 8; and 256B.0444, subds. 2 and 3
- Paragraph (h): Recodified in § 256B.0442, subd. 2
- Paragraph (i): Recodified in § 256B.0442, subd. 3
- Paragraph (j): Recodified in § 256B.044, subds. 1 and 5
- Paragraph (k): Recodified in § 256B.044, subd. 3
- Paragraph (l): Recodified in § 256B.0444, subd. 1
- Paragraph (m): Recodified in § 256B.044, subd. 6

**11 Medical assistance education program.**

Adds a subdivision to § 256B.04. Directs the commissioner to provide information to all MA enrollees on specified topics, including an enrollee's benefits, rights, and responsibilities under MA and an enrollee's right to file complaints, grievances, and appeals. Requires that the information provided is in plain language, is culturally and linguistically appropriate, and complies with federal requirements for communicating with MA enrollees. Allows the commissioner to require entities that participate in MA, like managed care plans, providers, and lead agencies, to assist in delivering the information. Provides that when the required information is provided to MA

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enrollees who receive case management services or have a support plan, the information must be tailored to the enrollees' service needs.

**12 Provider enrollment.**

Creates § 256B.044.

**Subd. 1. Designating categorical risk levels.** Directs the commissioner to assign a categorical risk level to provider types based on the criteria and standards used under Medicare. This is a recodification of part of section 256B.04, subdivision 21, paragraph (j), with technical modifications.

**Subd. 2. Required verifications and checks.** Directs the commissioner to conduct specified verifications and checks as part of enrolling providers in MA.

**Subd. 3. Required background studies.** Requires the commissioner to conduct background studies for all providers applying to enroll in MA and requires background studies for an individual with an ownership or control interest in, or who is an officer, director, agent or managing employee, or other person with operational or managerial control of, the provider. Provides that fingerprint-based background studies are required when mandated by federal law or when a provider is designated as moderate-risk or high-risk. Allows the commissioner to conduct postenrollment background studies as necessary. This is a recodification of parts of section 256B.04, subdivision 21, paragraphs (a) and (k), with substantive modifications.

**Subd. 4. Service location enrollment.** Requires that a provider enrolls each provider-controlled location where direct services are provided as a condition of enrolling in MA, with some exceptions. This is a recodification of part of section 256B.04, subdivision 21, paragraph (a), with substantive modifications.

**Subd. 5. Site visits.** Requires that providers allow the Centers for Medicare and Medicaid Services (CMS) and DHS to conduct unannounced site visits at any of the provider's MA-enrolled locations. Provides that the commissioner must conduct, for each MA provider that is designated moderate- or high-risk, pre-enrollment and postenrollment site visits, and directs the commissioner to conduct unannounced site visits for all providers within specified time frames. Allows the commissioner to conduct additional announced or unannounced site visits as necessary to verify compliance with enrollment requirements or protect program integrity. This is a recodification of part of section 256B.04, subdivision 21, paragraph (j), with substantive modifications.

**Subd. 6. Surety bonds.** Requires that a provider purchases a surety bond as a condition of enrollment in MA. The surety bond must be either \$50,000 or \$100,000 depending on the provider's MA revenue in the previous year. This is a

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recodification of section 256B.04, subdivision 21, paragraph (m), with substantive modifications.

**Subd. 7. Financial capacity.** Requires a provider to demonstrate sufficient financial capacity, as specified, in order to enroll as an MA provider. This is new language.

**Subd. 8. Compliance programs.** Allows the commissioner to require, as a condition of enrollment in MA, that an MA provider establish a compliance program that contains elements established by specified federal agencies. Directs an MA provider with a compliance program to designate an individual as a compliance officer and specifies duties for the officer. This is a recodification of section 256B.04, subdivision 21, paragraph (g), with substantive and technical modifications.

**Subd. 9. Incomplete provider enrollment applications.** Directs the commissioner to deny a provider's incomplete application for enrollment in MA if the provider does not respond to the commissioner's request for additional information within 60 days of the request. This is a recodification of part of section 256B.04, subdivision 21, paragraph (a), with a modification to make the denial a requirement.

**Subd. 10. Correspondence and notification.** Requires that the commissioner deliver correspondence and notifications, except those related to background studies, electronically to a provider's MN-ITS mailbox. This is a recodification of section 256B.04, subdivision 21, paragraph (e), with a modification to make the electronic notification a requirement.

**13 Provider revalidation.**

Creates § 256B.0441.

**Subd. 1. Requirement.** Provides that the commissioner must revalidate each MA provider according to this section. This is new technical language.

**Subd. 2. Schedule.** Specifies how often the commissioner must revalidate MA providers. Directs the commissioner to conduct revalidation more frequently when required under federal law or when necessary to protect program integrity. This is a recodification of section 256B.04, subdivision 21, paragraph (b), with substantive modifications.

**Subd. 3. Procedures.** Outlines the procedures the commissioner must follow when revalidating MA providers, which must include unannounced site visits at each of a provider's enrolled locations no more than 30 days prior to the provider's revalidation due date and demonstration of financial capacity. This is a

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recodification of section 256B.04, subdivision 21, paragraph (c), with substantive modifications.

**14 Provider enrollment, suspensions, and terminations.**

Creates § 256B.0442.

**Subd. 1. Suspension of billing privileges.** Requires that the commissioner suspend a provider's ability to bill if the provider is not in compliance with program requirements. Provides that the suspension must be in place until the provider comes into compliance. This is a recodification of section 256B.04, subdivision 21, paragraph (d), with substantive modifications.

**Subd. 2. Revocation for lack of documentation.** Allows the commissioner to revoke a provider's enrollment if the provider fails to maintain and provide the commissioner access to documentation related to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services for which the commissioner identifies a pattern of a lack of documentation. This is a recodification of section 256B.04, subdivision 21, paragraph (h), with technical modifications.

**Subd. 3. Mandatory denial or termination of enrollment.** Paragraph (a) adds to state statute, federal requirements governing when the commissioner must terminate or deny a provider's enrollment in MA. Paragraph (b) allows the commissioner to exempt a rehabilitation agency from termination or denial under certain circumstances. This is a recodification of section 256B.04, subdivision 21, paragraph (i).

**15 Provider payment withholds.**

Creates § 256B.0443. Upon a provider's initial enrollment in MA, allows the commissioner to withhold payments for a 90-day period if a provider is within a provider type that is designated high-risk by CMS or the commissioner. This is a recodification of section 256B.04, subdivision 21, paragraph (f).

**16 Enrollment moratorium for high-risk providers.**

Creates § 256B.0444.

**Subd. 1. Provider enrollment moratorium.** Allows the commissioner to issue a statewide or regional provider enrollment moratorium, for up to 24 months, for a provider type that is designated high-risk. Directs the commissioner to revalidate the enrollment of each provider within a provider type subject to the moratorium before ending the moratorium.

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**Subd. 2. Moratorium exceptions.** Allows the commissioner to grant exceptions to a provider enrollment moratorium if a county or Tribal agency requests an exception and the commissioner determines that the agency's request shows that enrollment of the new provider meets a specified criterion.

**Subd. 3. Continued enrollment of new clients.** Provides that a provider within a provider type subject to an enrollment moratorium may continue to enroll new clients or beneficiaries during the period of the enrollment moratorium.

**Subd. 4. Notice.** Directs the commissioner to issue notices to enrolled providers and the legislature at least ten days prior to implementing an enrollment moratorium.

**Subd. 5. Report to legislature.** Directs the commissioner to submit a report to the legislature about the enrollment moratorium within 60 days of ending the moratorium.

**17 Additional provider enrollment requirements for specific provider types.**

Creates § 256B.0445.

**Subd. 1. Durable medical equipment provider or supplier.** Provides specific MA enrollment requirements for providers or suppliers of durable medical equipment. This is a recodification of section 256B.04, subdivision 21, paragraph (l).

**Subd. 2. Providers licensed by the commissioner of human services.** Requires that an MA-enrolled provider that is licensed by the commissioner under chapter 245A must designate an individual as the licensee's compliance offer. This is a recodification of section 256B.04, subdivision 21, paragraph (g).

**Subd. 3. Providers licensed by the commissioner of health.** Requires that an MA-enrolled provider that is licensed by the commissioner of health as a home care provider under chapter 144A with a home and community-based services designation under section 144A.484 on the home care license, or as an assisted living facility under chapter 144G, must designate an individual as the licensee's compliance offer. This is a recodification of section 256B.04, subdivision 21, paragraph (g).

**18 Additional provider enrollment training requirements for high-risk providers.**

Proposes coding for § 256B.044.

**Subd. 1. Applicability.** Specifies that the new section applies to any entity enrolled in or applying to enroll in Minnesota health care programs as an MA

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provider that provides a service designated as high-risk under section 256B.04, subd. 21.

**Subd. 2. Mandatory training compliance.** Effective January 1, 2027, before enrollment or reenrollment, requires the entities specified in subdivision 1 to require all owners who are active in day-to-day management and all managerial and supervisory employees to complete compliance training. Requires those individuals to repeat training prior to revalidation of the entity.

Also requires new owners and managerial and supervisory employees to complete the training within 30 calendar days, and before conducting any management and operations activities. Specifies that an individual is not required to repeat training if the individual moves to another entity providing the same service and serves in a similar capacity.

Requires the commissioner to determine the format and content of the compliance training; lists required training topics.

**19 Enhanced prepayment review.**

Creates § 256B.0447.

**Subd. 1. Purpose and authority.** Directs the commissioner to conduct enhanced prepayment review of fee-for-service (FFS) MA claims.

**Subd. 2. Providers, services, and claims subject to review.** Identifies the circumstances under which the commissioner must establish enhanced prepayment review.

**Subd. 3. Review requirements.** Provides requirements for enhanced prepayment review, including when it must be implemented and the duration (up to 24 months). Prior to ending the review, directs the commissioner to review the FFS claims submitted during the period to determine whether continuing the review is warranted.

**Subd. 4. Notice.** Requires that the commissioner provide written notice to a provider subject to enhanced prepayment review at least 15 days prior to implementing the review, except when the notice would compromise program integrity, interfere with an audit or investigation, or conflict with federal law or guidance.

**Subd. 5. Continued enrollment of new clients.** Provides that nothing in this section prohibits enrolled providers subject to prepayment review from enrolling new clients or beneficiaries during the period of review.

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**Subd. 6. Timely claims processing.** Requires that the review comply with federal regulations with respect to timely processing of MA claims.

**Subd. 7. Duration and termination.** Provides that enhanced prepayment review may continue for up to 24 consecutive months unless the commissioner determines that earlier termination is appropriate based on sustained compliance or the commissioner has initiated an enforcement action that remains pending on appeal.

**Subd. 8. Relationship to other actions.** Provides that conducting enhanced prepayment review does not preclude the commissioner from taking other investigatory actions or imposing sanctions as allowed under state or federal law.

**Subd. 9. Report to the legislature.** Directs the commissioner to submit a report to the legislature within 60 days of ending an enhanced prepayment review and specifies the content of the report. Provides that the reporting requirement does not expire.

Makes this section effective January 1, 2027.

20 **Postpayment review.**

Creates § 256B.0448. Gives the commissioner the authority to conduct postpayment review of MA billings.

**Subd. 1. Purpose and authority.** Allows the commissioner to conduct postpayment review of MA claims, encounters, cost reports, rate submissions, and other billings submitted for payment or reimbursement.

**Subd. 2. Scope of review.** Allows the commissioner to conduct postpayment review on a claim-by-claim basis or through other review methods authorized under state or federal law.

**Subd. 3. Provider obligations.** Requires that a provider subject to postpayment review maintain documentation necessary to support billings submitted for payment or reimbursement. Allows the commissioner to require that a provider submit documents relevant to the review, and allows the commissioner to recover payments and impose sanctions if a provider fails to submit the required documentation according to the commissioner's timeline.

**Subd. 4. Recovery and sanctions.** Permits the commissioner to recover payments and impose sanctions based on the results of postpayment review.

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**Subd. 5. Relationship to other actions.** Provides that conducting postpayment review does not preclude the commissioner from taking other investigatory actions or imposing sanctions as allowed under state or federal law.

Makes this section effective January 1, 2027.

**21 Recipient protections and continuity of care when a provider is subject to a serious operational event.**

Creates § 256B.045. The duties in subdivisions 2 to 4 are largely reorganized and moved from the home care services (§ 256B.0651, subd. 17) and community first services and supports, or CFSS (§ 256B.85, subd. 23a), statutes and expanded to apply more broadly within MA.

**Subd. 1. Definitions.** For purposes of the sections governing MA recipient protections and continuity of care, defines the following terms:

- Complex transition
- Direct recipient care costs
- Lead agency
- Recipient
- Serious operational event

**Subd. 2. Provider duties.** Lists MA service provider duties if the provider determines it is unable to continue to provide services to a recipient due to a serious operational event.

**Subd. 3. Commissioner's duties.** Lists the commissioner's duties when a provider is subject to a serious operational event.

**Subd. 4. Lead agency duties.** Lists lead agency duties when a provider is subject to a serious operational event.

**22 Complex transitions.**

Creates § 256B.046.

**Subd. 1. Complex transition designation.** Lists conditions under which the commissioner must designate a serious operational event as a complex transition. Allows the commissioner to establish objective thresholds to create a presumption of complex transition based on the number of recipients affected by a serious operational event, recipient acuity, service type, or unresolved discharge or placement barriers.

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**Subd. 2. Complex transition operations plan.** Requires the commissioner to develop and implement a written complex transition operations plan for each complex transition. Lists the information that must be included in the plan.

**Subd. 3. Complex transition team.** Allows the commissioner to convene a complex transition team that includes department staff, lead agencies, and other professionals to ensure the safe transition of recipients from the provider that is unable to continue to provide services to another provider.

**Subd. 4. Complex transition; legislative notice.** Requires the commissioner to notify the legislature within ten days of designating a complex transition and provide a report within 90 days of recipient stabilization to identify systemic gaps and make recommendations for systemic improvements.

**23 Continuity period and transition payments for complex transitions.**

Creates § 256B.047.

**Subd. 1. Limited continuity period.** Allows a provider subject to a serious operational event that is designated as a complex transition to continue to provide services to high-risk recipients receiving certain services for up to 180 days after the date the serious operational event was designated a complex transition. Specifies the continuity period does not reinstate provider participation in MA or limit the commissioner's sanction, exclusion, recovery, licensing enforcement, or referral authority.

**Subd. 2. Good cause payment safeguards.** Allows the commissioner to find good cause not to suspend MA payments when payment withholds or reductions occur in order to provide for continuity of care during complex transitions.

**Subd. 3. Transition payments.** Requires payments to a provider to be limited to direct recipient care costs if the commissioner does not suspend MA payments to a sanctioned provider due to a determination of good cause. Requires a provider continuing to receive MA payments to submit to independent financial monitoring and a prohibition on financial distributions to owners. Requires the commissioner to prioritize payments to alternative enrolled MA providers that assume responsibility for service provision, court-appointed receivers or interim managers providing services, or substitute providers operating on-site under an approved complex transition operations plan.

**24 Agency qualification and duties.**

Amends § 256B.051, subd. 6. Updates a cross-reference related to the recodification of section 256B.04, subdivision 21.

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- 25     **Sanctions available.**  
Amends § 256B.064, subd. 1b. Adds paragraph lettering; numbers lists; updates terminology.
- 26     **Grounds for and methods of monetary recovery.**  
Amends § 256B.064, subd. 1c. Updates terminology.
- 27     **Investigative costs.**  
Amends § 256B.064, subd. 1d. Adds paragraph lettering; updates terminology.
- 28     **Imposition of monetary recovery and sanctions; generally.**  
Amends § 256B.064, subd. 2. Updates terminology and cross-references; removes language that is being moved to new subdivisions.
- 29     **Imposition of fines.**  
Amends § 256B.064 by adding subd. 2a. Adds new subdivision with language formerly in subdivision 2, paragraphs (g) and (h).
- 30     **Mandatory suspension or termination after exclusion from participation in Medicare.**  
Amends § 256B.064 by adding subd. 2b. Adds new subdivision with language formerly in subdivision 2, paragraph (e).
- 31     **Imposition of withholding or reduction of payments prior to a hearing.**  
Amends § 256B.064 by adding subd. 2c. Adds new subdivision with language formerly in subdivision 2, paragraph (a).
- 32     **Imposition of withholding or reduction of payments without prior notice.**  
Amends § 256B.064 by adding subd. 2d. Adds new subdivision with language formerly in subdivision 2, paragraphs (b) and (c).
- 33     **Forfeiture of withheld payments upon criminal conviction.**  
Amends § 256B.064 by adding subd. 2e. Adds new subdivision with language formerly in subdivision 2, paragraph (d).
- 34     **Mandates on prohibited payments.**  
Amends § 256B.064, subd. 3. Updates terminology and cross-references.
- 35     **Notice.**  
Amends § 256B.064, subd. 4. Updates terminology and cross-references.

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**36 Immunity; good faith reporters.**

Amends § 256B.064, subd. 5. Updates terminology.

**37 Suspension, withholding, or reduction of payments; administrative review.**

Amends § 256B.064 by adding subd. 6. Allows an individual or entity that is subject to a temporary withholding or reduction of payments without advance notice to request an administrative review before the state Court of Administrative Hearings within ten days of receiving notice of the action. Requires the commissioner to refer the matter to the Court of Administrative Hearings within five business days.

Requires the Court of Administrative Hearings to conduct an expedited hearing within 30 days, and lists what the administrative law judge must determine upon review. Requires the administrative law judge to issue a recommendation within ten days after a hearing, and requires the commissioner to issue a final determination ten days after that.

Allows the commissioner to modify the withholding to allow for partial payments during an investigation, if the administrative law judge determines that a full withholding would jeopardize access to medically necessary services.

**38 Periodic review of withholding or reduction of payments.**

Amends § 256B.064 by adding subd. 7. Requires the commissioner to review any temporary payment withholding or reduction at least every 90 days to determine whether the credible allegation of fraud continues to necessitate the action.

Requires the commissioner to provide a written status report on a specific withhold or reduction, to the relevant legislative committees, if the action remains in effect for 180 days or more.

**39 Coordination with law enforcement.**

Amends § 256B.064 by adding subd. 8. Requires the commissioner to coordinate with appropriate law enforcement authorities and allows for consultation with investigative agencies, when a temporary withholding or reduction of payments involves potential criminal conduct. Allows the commissioner to delay notice or disclosure of information from the entity being investigated, if law enforcement certifies that disclosure would compromise an ongoing criminal investigation.

**40 Application.**

Amends § 256B.064 by adding subd. 6. Specifies that section 256B.064 supersedes any inconsistent or contrary provision of law.

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- 41      **Remittance advice monetary recovery.**  
Amends § 256B.0647. Allows the commissioner to use the federal remittance advice process as the notice to a vendor or provider when seeking monetary recovery using a department-administered IT system for processed claims. Requires the remittance advice to be delivered electronically and requires the commissioner to withhold the payments at issue when this method of notice is used.  
  
Allows providers to seek reconsideration of a remittance under this section, and provides requirements and procedures for reconsideration requests.
- 42      **Recipient protection.**  
Amends § 256B.0651, subd. 17. Removes language related to recipient protection under home care services that has been moved to the new section 256B.045 and requires home care providers to meet the recipient protection requirements under that section when subject to a serious operational event.
- 43      **Provider qualifications and duties.**  
Amends § 256B.0701, subd. 9. Updates a cross-reference related to the recodification of section 256B.04, subdivision 21.
- 44      **Provider payment rates.**  
Amends § 256B.0759. Updates a cross-reference related to the recodification of section 256B.04, subdivision 21.
- 45      **Agency duties.**  
Amends § 256B.0949, subd. 16. Updates cross-references related to the recodification of section 256B.04, subdivision 21.
- 46      **Provider shortage; authority for exceptions.**  
Amends § 256B.0949, subd. 17. Updates a cross-reference related to the recodification of section 256B.04, subdivision 21.
- 47      **Managed care contracts.**  
Amends § 256B.69, subd. 5a. Requires that managed care plans that contract with MA have prepayment review processes in place and publish metrics related to program integrity actions on a publicly available website. Gives the commissioner the right to recover from a managed care plan the full amount of any claims identified as improperly paid during audits or investigations by DHS, its contractors, or CMS.

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- 48      **Duties when a provider is no longer able to provide services.**  
Amends § 256B.69. Lays out managed care and county-based purchasing plan duties when a provider is subject to a serious operational event.
- 49      **Sanctions; information for participants upon termination of services.**  
Amends § 256B.85, subd. 23a. Removes language related to recipient protection under CFSS that has been moved to the new section 256B.045 and requires CFSS and financial management services providers to meet the recipient protection requirements under that section when subject to a serious operational event.
- 50      **Mandatory compliance training for currently enrolled high-risk medical assistance providers.**  
Requires owners and individuals subject to the new training requirement, enrolled in MA before January 1, 2027, to complete initial compliance training by January 1, 2028.
- 51      **Repealer.**  
Repeals Minn. Stat. § 256B.0701, subd. 11 (requirements for provider enrollment; compliance training).

## **Article 2: Department of Human Services Office of Inspector General Policy**

This article makes changes related to payment withholding and other disciplinary and licensing actions by the Department of Human Services, aligns fraud definitions in statute, and clarifies and modifies fraud investigation procedures and pre- and post-payment review authority in medical assistance (MA). The article also modifies background study disqualifications and other background study requirements for certain providers, modifies emergency overdose treatment requirements for certain programs, clarifies and modifies requirements related to surety bonds for MA provider agencies, and makes technical changes.

**Section Description - Department of Human Services Office of Inspector General Policy**

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- 1      **Exception.**  
Amends § 13A.03 by adding subd. 2a. Allows law enforcement to delay notification to a customer of obtaining access to the customer's financial records, or to authorize a delay for another government entity, without a court order, if law enforcement makes a written determination that notification would compromise an ongoing investigation. Requires the written determination to be renewed every 90 days.

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**2 Definitions.**

Amends § 245.095, subd. 2. Adds definitions for “convicted,” “credible allegation of fraud,” and “fraud,” and modifies the definition of “excluded” in the section governing limits on receiving public funds from the Department of Human Services.

**3 Withholding of payments.**

Amends § 245.095, subd. 5. Adds criteria related to offenses involving fraud or theft, background study disqualifications, and licensing actions, that would allow the commissioner to withhold payments to a provider, vendor, individual, or associated individual or entity in any human services program. Clarifies in paragraph (f) that section 15.013 (program payments withheld; fraud) does not apply to the commissioner’s withholding actions.

**4 Immediate suspension expedited hearing.**

Amends § 245A.07, subd. 2a. Makes clarifying changes; adds controlling individuals; adds requirement for the commissioner to suspend a license holder or controlling individual who is the subject of a pending investigation or civil action related to fraud against a government program; specifies that the burden of proof in expedited hearings is a preponderance of the evidence.

**5 License suspension, revocation, or fine.**

Amends § 245A.07, subd. 3. Updates cross-reference.

**6 License or certification fee for certain programs.**

Amends § 245A.10, subd. 4. Makes technical changes.

**7 Provisional license.**

Amends § 245A.142, subd. 3. Adds paragraph (f), specifying an initial provisional early intensive developmental and behavioral intervention license application fee of \$2,100.

Provides an immediate effective date.

**8 Emergency overdose treatment.**

Amends § 245A.242, subd. 2. Allows a license holder who is required to maintain a supply of opiate antagonists to do so without a written standing order protocol; requires a written standing order protocol only for opiate antagonists administered via intramuscular injection.

<b>Section</b>	<b>Description - Department of Human Services Office of Inspector General Policy</b>
9	<p><b>Serious maltreatment.</b></p> <p>Amends § 245C.02, subd. 18. For background study disqualification purposes, adds financial exploitation of a vulnerable adult in the amount of \$1,000 or more to the definition of serious maltreatment.</p>
10	<p><b>Programs licensed by the commissioner.</b></p> <p>Amends § 245C.03, subd. 1. Adds children’s foster residence settings to list of licensed programs for which background studies must be conducted.</p> <p>Provides a November 3, 2026, effective date.</p>
11	<p><b>Licensed programs; other child care programs.</b></p> <p>Amends § 245C.04, subd. 1. Strikes language that allowed the commissioner to not conduct a study of an individual at the time of reapplication under certain circumstances. Adds language to require currently affiliated child and adult foster care providers and child care providers to have a background study submitted under NETStudy 2.0 (the current background study system), if they do not already have one.</p>
12	<p><b>Study subject affiliated with multiple facilities.</b></p> <p>Amends § 245C.07. Removes language allowing child foster care background studies to be transferable across all licensed programs.</p> <p>Provides a July 1, 2026, effective date.</p>
13	<p><b>Activities pending completion of a background study.</b></p> <p>Amends § 245C.13, subd. 2. Clarifies child care background study notice requirements; clarifies that a child care background study subject may not perform direct contact services before receiving relevant notices, except if the study is a renewal and it has been less than five years since the study subject was previously disqualified or provided notice that they are not disqualified.</p> <p>Provides a July 1, 2026, effective date.</p>
14	<p><b>15-year disqualification.</b></p> <p>Amends § 245C.15, subd. 2. Adds felony-level illegal remunerations and violation of an order for protection against financial exploitation of a vulnerable adult to the list of disqualifying offenses for background studies.</p>
15	<p><b>Ten-year disqualification.</b></p> <p>Amends § 245C.15, subd. 3. Adds gross misdemeanor-level interference with privacy and violation of an order for protection against financial exploitation of a vulnerable adult to the list of disqualifying offenses for background studies.</p>

**Section Description - Department of Human Services Office of Inspector General Policy**

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- 16      **Seven-year disqualification.**  
Amends § 245C.15, subd. 4. Adds misdemeanor-level violation of an order for protection against financial exploitation of a vulnerable adult to the list of disqualifying offenses for background studies.
- 17      **Licensed family foster setting disqualifications.**  
Amends § 245C.15, subd. 4a. Updates cross-references.
- 18      **Scope of set-aside.**  
Amends § 245C.22, subd. 5. Updates cross-reference.
- 19      **Permanent bar to set aside a disqualification.**  
Amends § 245C.24, subd. 2. Strikes paragraph (g), which prohibits a set aside or variance for certain crimes or conduct related to foster residence settings and children’s residential facilities. Updates cross-reference.
- 20      **Protection-related rights.**  
Amends § 245D.04, subd. 3. Clarifies that certain 245D resident rights cannot be restricted.  
  
Provides an immediate effective date.
- 21      **Availability of current written policies and procedures.**  
Amends § 245D.10, subd. 4. Adds that a 245D license holder may inform a person’s legal representative of the policies and procedures affecting the person’s rights. Adds the emergency use of manual restraints policy and procedure to those that must be provided.  
  
Provides an immediate effective date.
- 22      **Fraud.**  
Amends § 256B.02 by adding subd. 20. Defines “fraud” under chapter 256B.
- 23      **Investigation of certain crimes.**  
Amends § 256B.04, subd. 10. Specifies that the commissioner has the authority to conduct prepayment and postpayment review of MA claims submitted by vendors. Adds language clarifying the commissioner’s authority.
- 24      **Agency qualifications and duties.**  
Amends § 256B.051, subd. 6. Requires surety bonds for MA provider agencies to be purchased new annually, rather than renewed.

<b>Section</b>	<b>Description - Department of Human Services Office of Inspector General Policy</b>
25	<p><b>Imposition of monetary recovery and sanctions.</b></p> <p>Amends § 256B.064, subd. 2. Adds language to align the description of a credible allegation of fraud with the description in section 245.095.</p>
26	<p><b>Requirements for provider enrollment of personal care assistance provider agencies.</b></p> <p>Amends § 256B.0659, subd. 21. Requires surety bonds for personal care assistance provider agencies to be purchased new annually, rather than renewed.</p>
27	<p><b>Provider qualifications and duties.</b></p> <p>Amends § 256B.0701, subd. 9. Requires surety bonds for recuperative care services provider agencies to be purchased new annually, rather than renewed.</p>
28	<p><b>Access to medical records.</b></p> <p>Amends § 256B.27, subd. 3. Expands the commissioner's authority to conduct on-site inspections of MA vendors and service locations and to request records from a vendor.</p>
29	<p><b>Requirements for enrollment of CFSS agency-providers.</b></p> <p>Amends § 256B.85, subd. 12. Requires surety bonds for community first services and supports (CFSS) provider agencies to be purchased new annually, rather than renewed.</p>
30	<p><b>Consultation services provider qualifications and requirements.</b></p> <p>Amends § 256B.85, subd. 17a. Requires surety bonds for consultation services provider agencies to be purchased new annually, rather than renewed. Specifies that any action to obtain monetary recovery or sanctions from a surety bond under this subdivision must occur within six years from the date the debt is affirmed by a final agency decision.</p>
31	<p><b>Facility.</b></p> <p>Amends § 260E.04, subd. 6. Adds psychiatric residential treatment facilities (PRTFs) to definition of "facility" in the Maltreatment of Minors Act.</p>
32	<p><b>Reports of maltreatment in a facility.</b></p> <p>Amends § 260E.11, subd. 1. Specifies that maltreatment in a PRTF must be reported to the Department of Health (MDH).</p>
33	<p><b>Facilities and schools.</b></p> <p>Amends § 260E.14, subd. 1. Specifies that MDH is the agency responsible for screening and investigating allegations of maltreatment in PRTFs.</p>

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**Section Description - Department of Human Services Office of Inspector General Policy**

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- 34     **Lead investigative agency.**  
Amends § 626.5572, subd. 13. Modifies the definition of “lead investigative agency” for the Vulnerable Adults Act to add PRTFs.
- 35     **New background studies for individuals not in NETStudy 2.0.**  
Requires individuals affiliated with child and adult foster care, family adult day services, family child care, or legal nonlicensed child care providers to have a new background study completed through NETStudy 2.0, by March 1, 2027.  
  
Provides a September 1, 2026, effective date.
- 36     **Repealer.**  
Paragraph (a) repeals section 245A.10, subdivision 3a (fee for change of ownership exception), effective October 1, 2026.  
  
Paragraph (b) repeals Minnesota Rules, part 9505.2165, subpart 4 (definition of fraud, modified and moved to statute).

### **Article 3: Background Studies**

This article makes changes to human services background study sections in chapter 245C. It modifies national criminal history record check and fingerprint requirement exceptions, adds board members and other individuals required to complete background studies across different service types, modifies statutes prohibiting the provision of services while a background study is pending, and makes technical and clarifying changes.

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**Section Description - Article 3: Background Studies**

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- 1     **Reasonable cause to require a national criminal history record check.**  
Amends § 245C.02, subd. 15a. Specifies that reasonable cause to require a national criminal history check does not apply to adult day services or adult foster care studies (federal compliance change).  
  
Provides a January 25, 2028, effective date.
- 2     **Personal care assistance provider agency; background studies.**  
Amends § 245C.03, subd. 3a. Adds board members and volunteers to those who are subject to a background study for personal care assistance (PCA) provider agencies enrolled in medical assistance (MA).

**Section Description - Article 3: Background Studies**

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- Provides a September 15, 2026, effective date.
- 3 Community first services and supports and financial management services organizations.**  
Amends § 245C.03, subd. 9. Adds board members and volunteers to those who are subject to a background study for community first services and supports (CFSS) and Financial Management Services providers enrolled in MA.  
Provides a September 15, 2026, effective date.
- 4 Providers of adult rehabilitative mental health services.**  
Amends § 245C.03 by adding subd. 17. For adult rehabilitative mental health providers, requires the commissioner to conduct background studies on any individual with an ownership stake of at least five percent, operator, or employee or volunteer who has direct contact with people receiving services. Specifies that “operator” includes board members.  
Makes this section effective upon its implementation in NETStudy 2.0, no sooner than October 13, 2026.
- 5 Providers of peer recovery support services.**  
Amends § 245C.03 by adding subd. 18. For peer recovery support services providers, requires the commissioner to conduct background studies on any individual with an ownership stake of at least five percent, operator, or employee or volunteer who has direct contact with people receiving services. Specifies that “operator” includes board members.  
Makes this section effective upon its implementation in NETStudy 2.0, no sooner than December 15, 2026.
- 6 Providers of adult assertive community treatment services.**  
Amends § 245C.03 by adding subd. 19. For adult assertive community treatment providers, requires the commissioner to conduct background studies on any individual with an ownership stake of at least five percent, operator, or employee or volunteer who has direct contact with people receiving services. Specifies that “operator” includes board members.  
Makes this section effective upon its implementation in NETStudy 2.0, no sooner than February 16, 2027.

**Section Description - Article 3: Background Studies**

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**7 Fingerprints and photograph.**

Amends § 245C.05, subd. 5. Adds adult day services and adult foster care to the exceptions to the requirement for the Department of Human Services to maintain a set of classifiable fingerprints on background study subjects.

Provides a January 25, 2028, effective date.

**8 Activities pending completion of a background study.**

Amends § 245C.13, subd. 2. Adds early intensive developmental and behavioral intervention (EIDBI), housing support or supplementary services, special transportation services, and CFSS providers to provision requiring notice that an individual is not disqualified or notice of a disqualification that has been set aside, before the individual provides services. Strikes clause (8) due to EIDBI being moved to clause (7).

Provides a September 15, 2026, effective date.

**9 Determining immediate risk of harm.**

Amends § 245C.16, subd. 1. Makes conforming changes to paragraph (e) related to PCA and EIDBI background studies.

Provides a September 15, 2026, effective date.

## **Article 4: Behavioral Health**

This article moves forward effective dates for the phase-out of free-standing room and board behavioral health fund payments, and for provisions related to recovery residences. The article also establishes medical assistance (MA) coverage for detained individuals and establishes an MA benefit for carceral targeted case management services.

**Section Description - Article 4: Behavioral Health**

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**1 Eligible vendor requirements.**

Amends § 254B.0504, subd. 1. Moves forward the final date for phasing out free-standing room and board behavioral health fund payments from June 30, 2027, to December 31, 2026.

Provides an immediate effective date.

**Section Description - Article 4: Behavioral Health**

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- 2 Coverage for detained individuals.**  
Proposes coding for § 256B.0618. Establishes MA eligibility for inmates of correctional facilities who are conditionally released, under listed circumstances. Specifies that individuals who are considered inmates of public institutions are not eligible for MA, except under listed circumstances. Specifies that the entity that has jurisdiction over the inmate is responsible for security-related costs and logistics for inpatient treatment.  
  
Provides a January 1, 2027, effective date.
- 3 Carceral targeted case management services.**  
Proposes coding for § 256B.0619. Establishes a benefit under MA for carceral case management services, effective January 1, 2027, or upon federal approval. Provides definitions, eligibility requirements, a description of the services, and provider standards, and specifies payment rates.  
  
Provides an immediate effective date.
- 4 Carceral targeted case management.**  
Amends § 256B.0625 by adding subd. 77. Establishes carceral targeted case management services MA benefit, effective January 1, 2027, or upon federal approval.
- 5 Eligible individuals.**  
Amends § 256B.0761, subd. 2. Makes conforming change.
- 6 to 15 Effective dates.**  
Moves forward effective dates for changes made to recovery residence provisions, and establishing certification, from January 1, 2027, to July 1, 2026.
- 16 Recovery residence work group.**  
Moves forward the final report due date for the recovery residence work group from January 1, 2027, to July 1, 2026.
- 17 Direction to commissioner; carceral targeted case management services billing units.**  
Requires the commissioner to establish a new billing code for carceral targeted case management services, and to identify reimbursement rates for the newly defined codes. Specifies requirements for new billing codes.  
  
Provides an effective date of January 1, 2027, or upon federal approval, whichever is later.

**Section Description - Article 4: Behavioral Health**

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**18 Repealer.**

Repeals § 256B.055, subd. 14 (MA eligibility; persons detained by law).

Provides an effective date of January 1, 2027, or upon federal approval, whichever is later.

## **Article 5: Uniform Service Standards**

This article transitions the following services from certification to licensure: adult rehabilitative mental health services (ARMHS); children’s therapeutic services and supports (CTSS), including children’s day treatment; crisis response services; and certified community behavioral health clinic (CCBHC) services. The article also makes technical and conforming changes to account for the transition to licensure for these services.

**Section Description - Article 5: Uniform Service Standards**

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**1 Section 223 of the Protecting Access to Medicare Act entities.**

Amends § 245.735, subd. 6. Strikes CCBHC demonstration program language that is made unnecessary by the new sections added in the article related to CCBHC licensing.

**2 Exclusion from licensure.**

Amends § 245A.04, subd. 2. Conforming change; adds programs licensed under new section 245A.044 to indicate that they must be licensed by DHS.

Provides a January 1, 2028, effective date.

**3 Licensed nonresidential behavioral health services.**

Proposes coding for § 245A.044. Specifies that beginning January 1, 2028, ARMHS, CTSS, crisis response services, and CCBHC providers must be licensed under chapter 245A, and must comply with the requirements of chapter 245I and applicable rules. Specifies licensing transition implementation timeline and procedures.

Provides a July 1, 2026, effective date.

**4 Application fee for initial license or certification.**

Amends § 245A.10, subd. 3. Modifies initial mental health clinic certification application fee and adds initial license application fee for CCBHCs. Makes technical change.

**Section Description - Article 5: Uniform Service Standards**

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- 5        **License or certification fee for certain programs.**  
Amends §245A.10, subd. 4. Adds annual license fees for newly licensed behavioral health services and for CCBHCs.
- 6        **Fees for satellite locations.**  
Amends § 245A.10 by adding subd. 4a. Moves provisions related to licensing fees for satellite locations and adds satellite location fees for newly licensed behavioral health services providers.
- 7        **Determination of vulnerable adult status.**  
Amends § 245A.65, subd. 1a. Requires a license holder providing mobile crisis services to determine whether an individual is a vulnerable adult within 24 hours of first providing crisis stabilization services.
- 8        **Programs licensed by the commissioner.**  
Amends § 245C.03, subd. 1. Adds newly licensed services to the list of programs to which chapter 245C background study requirements apply.
- 9        **Activities pending completion of a background study.**  
Amends § 245C.13, subd. 2. Adds early intensive developmental and behavioral intervention and ARMHS to provision requiring notice that an individual is not disqualified or notice of a disqualification that has been set aside before the individual provides services.
- 10       **Determining immediate risk of harm.**  
Amends § 245C.16, subd. 1. Makes conforming change.
- 11       **License requirements.**  
Amends § 245G.03, subd. 1. Updates cross-references.
- 12       **Certification required.**  
Amends § 245I.011, subd. 3. Updates cross-reference; removes language relating to certification of CCBHCs.  
  
Provides an immediate effective date, and an effective date for the stricken language of January 1, 2028.
- 13       **Programs certified under chapter 256B.**  
Amends § 245I.011, subd. 5. Strikes certification language for newly licensed services.  
  
Provides a January 1, 2028, effective date.

**Section Description - Article 5: Uniform Service Standards**

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- 14     **License required for nonresidential programs.**  
Amends § 245I.011 by adding subd. 6. Requires licensure beginning January 1, 2028, for providers of ARMHS, CTSS, crisis response services, and CCBHC services. Requires that the provider entities remain certified until the commissioner issues a license, denies a license, or the certification expires.
- 15     **Alcohol and drug counselor.**  
Amends § 245I.02 by adding subd. 1a. Adds definition of “alcohol and drug counselor” to chapter 245I.
- 16     **Comprehensive evaluation.**  
Amends § 245I.02 by adding subd. 10a. Adds definition of “comprehensive evaluation” to chapter 245I.
- 17     **Initial evaluation.**  
Amends § 245I.02 by adding subd. 18a. Adds definition of “initial evaluation” to chapter 245I.
- 18     **Psychotherapy.**  
Amends § 245I.02 by adding subd. 31a. Adds definition of “psychotherapy” to chapter 245I.
- 19     **Rehabilitative mental health services.**  
Amends § 245I.02, subd. 33. Modifies definition to specify differences for child clients, and to specify additional aspects of the services.
- 20     **Treatment plan.**  
Amends § 245I.02, subd. 39. Modifies definition to specify that for CCBHC services, a treatment plan is the integrated treatment plan.
- 21     **Behavioral emergencies.**  
Amends § 245I.03, subd. 4. Adds requirement for license holder behavioral emergency procedures to include the contact information for the local crisis team.
- 22     **Quality assurance and improvement plan.**  
Amends § 245I.03 by adding subd. 11. Establishes requirements for a license holder to develop a written quality assurance and improvement plan; specifies what the plan must include; requires annual review and updates.

**Section Description - Article 5: Uniform Service Standards**

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- 23      **Behavioral health practitioner scope of practice.**  
Amends § 2451.04, subd. 5. Adds crisis planning to the scope of practice for behavioral health practitioners.
- 24      **Mental health behavioral aide scope of practice.**  
Amends § 2451.04, subd. 17. Modifies mental health behavioral aide scope of practice to only allow them to provide skill-building services to a child client.
- 25      **Generally.**  
Amends § 2451.06, subd. 1. Adds modeling respectful and inclusive service practices to treatment supervision requirements.
- 26      **Treatment supervision planning.**  
Amends § 2451.06, subd. 2. Adds approval by the staff person to treatment supervision plan requirements; makes technical change.
- 27      **Personnel files.**  
Amends § 2451.07. Adds paragraph (c), requiring CCBHC personnel files for staff who provide substance use disorder (SUD) treatment services to include records of required training.
- 28      **Evaluation, treatment authorization, and planning in a certified community behavioral health clinic.**  
Amends § 2451.10 by adding subd. 2a. Requires a CCBHC license holder to meet specified statutory requirements for assessments, treatment planning, and service planning and authorization.
- 29      **Standard diagnostic assessment; required elements.**  
Amends § 2451.10, subd. 6. Adds requirements for standard diagnostic assessments of clients 12 to 17 years of age. Strikes requirement for the assessor to make referrals for the client. Adds requirement in paragraph (h) for the assessor to document actions that will be taken for co-occurring mental health and SUD conditions. Adds paragraph (i), requiring the assessor to determine a client's eligibility for targeted case management services and refer the client as appropriate.
- 30      **Individual treatment plan; required elements.**  
Amends § 2451.10, subd. 8. Adds case manager to individuals whose exclusion from treatment planning must be explained and documented. Requires updates to individual treatment plan as necessary to reflect the client's changing needs; requires the individual treatment plan to provide assistance with accessing crisis services if necessary.

**Section Description - Article 5: Uniform Service Standards**

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- 31      **Certified community behavioral health clinic licensure.**  
Proposes coding for § 245I.17. Establishes licensure requirements for CCBHCs, beginning January 1, 2028. Defines terms; specifies license extension allowances; lists required services and procedures; defines the scope of the licensure; provides for designated collaborating organization contracting; allows exemptions from host county approval requirements and for licensing variances; requires the commissioner to issue a list of required evidence-based practices; and requires a community needs assessment, a staffing plan, data and evaluation documentation, and cost reporting.
- 32      **Adult rehabilitative mental health services.**  
Proposes coding for § 245I.22. Establishes licensure requirements for ARMHS, beginning January 1, 2028. Defines terms; lists required service components and procedures; requires service planning; and specifies group modality requirements.
- 33      **Mobile crisis response services.**  
Proposes coding for § 245I.24. Establishes licensure requirements for mobile crisis response in community settings, beginning January 1, 2028. Defines terms; specifies client eligibility for crisis assessment, intervention, and stabilization services; lists required services, policies, and procedures; lists staff qualifications; specifies crisis screening, assessment, intervention, and stabilization service, and supervision requirements; specifies application requirements.
- 34      **Children’s therapeutic services and supports.**  
Proposes coding for § 245I.30. Establishes licensure requirements for CTSS community-based mental health services for children, beginning January 1, 2028. Lists required service components and provider and staff qualifications and requirements; specifies group modality requirements.
- 35      **Children’s day treatment.**  
Proposes coding for § 245I.22. Establishes licensure requirements for children’s day treatment programs, beginning January 1, 2028. Defines the service; lists required service components and procedures; lists provider and staff requirements and qualifications.
- 36      **Scope.**  
Amends § 256B.0623, subd. 1. Adds cross-reference to new licensure statute for ARMHS.  
  
Provides a January 1, 2028, effective date.

**Section Description - Article 5: Uniform Service Standards**

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- 37     **Eligibility.**  
Amends § 256B.0623, subd. 1. Adds cross-reference to standard diagnostic assessment statute.  
  
Provides a January 1, 2028, effective date.
- 38     **Additional requirements.**  
Amends § 256B.0623, subd. 1. Removes language from ARMHS MA statute that is moved to new licensing statute under chapter 245I.  
  
Provides a January 1, 2028, effective date.
- 39     **Scope.**  
Amends § 256B.0624, subd. 1. Adds cross-reference to new licensure statute for mobile crisis response services.  
  
Provides a January 1, 2028, effective date.
- 40     **Provider entity standards.**  
Amends § 256B.0624, subd. 4. Removes language from mobile crisis MA statute that is moved to new licensing statute under chapter 245I. Adds reference to emergency mental health services statute.  
  
Provides a January 1, 2028, effective date.
- 41     **Residential crisis stabilization services in adult foster care settings.**  
Amends § 256B.0624 by adding subd. 7a. Adds subdivision outlining staffing requirements for residential crisis stabilization services provided in settings that serve no more than four adult residents. Requires the commissioner to establish a statewide per diem rate for these services; includes cross-reference to crisis response licensure statute.  
  
Provides a January 1, 2028, effective date.
- 42     **Certified community behavioral health clinic services.**  
Amends § 256B.0625, subd. 5m. Adds cross-references to CCBHC licensure statute; makes technical changes.  
  
Provides a January 1, 2028, effective date.
- 43     **Covered service components of children's therapeutic services and supports.**  
Amends § 256B.0943, subd. 2. Adds cross-references to CTSS and children's day treatment licensure statutes; removes language moved to licensure statutes; adds

**Section Description - Article 5: Uniform Service Standards**

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paragraph (c), requiring providers to document the use of psychotherapy as part of a child's treatment; adds paragraph (d), specifying that MA covers service plan development before the completion of a child's individual treatment plan; adds paragraph (e), specifying that MA covers the time spent administering and reporting standardized measures for CTSS.

Provides a January 1, 2028, effective date.

**44 Determination of client eligibility.**

Amends § 256B.0943, subd. 3. Makes conforming changes.

**45 Excluded services.**

Amends § 256B.0943, subd. 12. Adds paragraph (b), specifying that CTSS payments include time spent on administrative tasks before and after providing direct services.

**46 Facilities and schools.**

Amends § 260E.14, subd. 1. Adds paragraph (h), specifying that DHS is responsible for screening and investigating child maltreatment reports for mobile crisis response services and CTSS programs.

**47 Lead investigative agency.**

Amends § 626.5572, subd. 13. Updates Vulnerable Adults Act to specify that DHS is the lead investigative agency for mental health programs licensed under chapter 245I, ARMHS, mobile crisis response services, and CCBHCs.

Provides a January 1, 2028, effective date.

**48 Revisor instruction.**

Instructs the revisor to renumber listed statutes.

**49 Repealer.**

Paragraph (a) repeals sections 245.735, subdivisions 1a, 2a, 3a, 3b, 3c, 3d, 3e, 3f, 3g, 3h, 4a, 4b, 4c, 4e, 7, and 8 (CCBHC services); 245C.03, subdivision 7 (CTSS provider background studies); 245I.20, subdivision 9 (mental health clinic quality assurance and improvement plan); 245I.23, subdivision 23 (IRTS and residential crisis stabilization quality assurance and improvement plan); 256B.0623, subdivisions 2, 4, 5, 6, and 9 (ARMHS subdivisions moved to 245I); 256B.0624, subdivisions 2, 3, 4a, 5, 6, 6a, 6b, 7, 8, 9, and 11 (crisis response services subdivisions moved to chapter 245I); and 256B.0943, subdivisions 4, 5, 5a, 6, 7, and 11 (CTSS subdivisions moved to chapter 245I).

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**Section Description - Article 5: Uniform Service Standards**

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Paragraph (b) repeals sections 245.735, subdivisions 3 and 4d (CCBHC service and integrated treatment plan requirements) and 256B.0943, subdivisions 1 and 9 (CTSS definitions and service delivery criteria).

Provides a January 1, 2028, effective date.

## **Article 6: Aging and Disability Services**

This article contains provisions establishing moratoria on integrated community supports and customized living and 24-hour customized living, establishing billing limits for various behavioral health and disability services, expanding electronic visit verification, modifying MnCHOICES, requiring additional documentation for residential support services providers, establishing a waiver case management advisory working group, establishing a MnCHOICES redesign working group, and requiring the commissioner of human services to evaluate and conduct studies on various services and programs.

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**Section Description - Article 6: Aging and Disability Services**

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**1 Integrated community supports.**

Amends § 245D.12. Establishes a moratorium on the issuance of integrated community supports licenses and prohibits the commissioner from approving a license change adding integrated community supports to an existing license. Allows the commissioner to approve exceptions to the moratorium under specified conditions. Specifies a determination is final and not subject to appeal.

Provides a January 1, 2027, effective date.

**2 Billing limits.**

Amends § 256B.0623, by adding subd. 15. Establishes billing limits for adult rehabilitation mental health services.

Provides a January 1, 2027, effective date.

**3 Transportation costs.**

Amends § 256B.0625, subd. 17. Effective January 1, 2027, or upon federal approval, whichever is later, specifies MA covers nonemergency medical transportation (NEMT) provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. Requires providers and drivers to meet certain requirements. Requires NEMT providers to comply with electronic visit verification requirements. Exempts publicly operated transit systems, volunteers, and not-for-hire vehicles from these requirements.

**Section Description - Article 6: Aging and Disability Services**

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Provides an immediate effective date.

**4 Documentation required.**

Amends § 256B.0625, subd. 17b. Effective January 1, 2027, or upon federal approval, whichever is later, allows records that comply with electronic visit verification to be used to meet the NEMT documentation requirements if all required elements are included in the record.

Provides an immediate effective date.

**5 Documentation; establishment and operation.**

Amends § 256B.073, subd. 1. Makes technical changes.

**6 Definitions.**

Amends § 256B.073, subd. 2. Modifies existing definitions and adds new definitions to the section of statute governing electronic visit verification. The new definitions include the following:

- Data aggregator
- Electronic visit verification data
- Electronic visit verification vendor
- Financial management services provider
- Individual
- Managed care organization
- Provider
- State-provided electronic visit verification system
- Third-party electronic visit verification system
- Verification method
- Visit
- Worker

**7 Requirements.**

Amends § 256B.073, subd. 3. Modifies electronic visit verification system requirements, updates terminology, and makes technical changes. Allows the commissioner to: (1) establish implementation dates and schedules for services or system functions subject to electronic visit verification, including the phased addition of new services, verification methods, or technical requirements; and (2) waive electronic visit verification requirements for any service component or setting under specified conditions.

**Section Description - Article 6: Aging and Disability Services**

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**8 Electronic visit verification system options.**

Amends § 256B.073, by adding subd. 4a. Requires a provider to use an electronic visit verification system that complies with the requirements established by the commissioner. Allows a provider to use either the state-provided system or a third-party system. Requires the commissioner to: (1) make a state-provided electronic visit verification system available at no cost to providers; (2) provide training on the system to all providers; and (3) allow providers to utilize a third-party electronic visit verification system that the commissioner determines meets the requirements of this section. Lists duties of providers using a third-party electronic visit verification system. Requires the state-designated data aggregator to be available at no cost to a provider for purposes of transmitting electronic visit verification data from approved third-party systems to the commissioner, and requires the commissioner to provide training on reviewing and correcting imported data in the state's designated data aggregator to providers.

**9 Provider responsibilities.**

Amends § 256B.073, by adding subd. 4b. Lists provider duties related to electronic visit verification.

**10 Vendor requirements.**

Amends § 256B.073, subd. 5. Updates terminology.

**11 Data and documentation.**

Amends § 256B.073, by adding subd. 6. Specifies how providers must record and submit electronic visit verification data to the commissioner and the data aggregator and how the commissioner and managed care organizations must use the data. Describes manual visits and specifies a manual visit does not comply with electronic visit verification requirements. Lays out duties of workers providing services subject to electronic visit verification. Requires providers to maintain documentation demonstrating compliance with electronic visit verification requirements and make the documentation available to the commissioner or a managed care organization under contract with the commissioner upon request.

**12 Third-party system responsibilities.**

Amends § 256B.073, by adding subd. 7. Requires providers that use a third-party electronic visit verification system to ensure that the system meets all requirements established by the commissioner and transmits data to the commissioner or the commissioner's designated data aggregator in the format and frequency required by the commissioner. Lists duties of a third-party electronic visit verification vendor. Specifies providers remain responsible for ensuring compliance with electronic visit verification requirements.

**Section Description - Article 6: Aging and Disability Services**

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- Provides an immediate effective date.
- 13     **Use of MnCHOICES certified assessors required.**  
Amends § 256B.0911, subd. 14. Requires the commissioner to employ certified assessors to conduct assessments on behalf of lead agencies under conditions and circumstances determined by the commissioner. Allows certified assessors employed by the department to conduct assessments in addition to other duties as assigned, except the certified assessors employed by the department must not perform any lead agency responsibilities under long-term care consultations other than assessments.
- 14     **Administrative activity.**  
Amends § 256B.0911, subd. 32. Requires the commissioner to grant limited role-based access to a person’s support plan in the MnCHOICES system to home and community-based services providers who have been designated as a provider for that person by a lead agency for specified purposes.
- 15     **Billing limits.**  
Amends § 256B.0949, by adding subd. 19. Effective July 1, 2027, or upon federal approval, whichever is later, establishes billing limits for early intensive developmental and behavioral intervention services and establishes an exception process when services in excess of the billing limits are determined to be medically necessary.
- 16     **Informed choice in technology policy.**  
Amends § 256B.4905, subd. 11. Modifies informed choice in technology policy for people with disabilities to specify the criteria under which people with disabilities have the right to make an informed choice about the use of remote supports.  
  
Provides an immediate effective date.
- 17     **Informed choice and technology prioritization in implementation for disability waiver services.**  
Amends § 256B.4905, subd. 12. Expands the commissioner’s duties related to ensuring informed choice and technology prioritization as it relates to remote supports.  
  
Provides an immediate effective date.

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**18 Billing limits.**

Amends § 256B.4912, by adding subd. 17. Effective January 1, 2027, or upon federal approval, whichever is later, establishes billing limits for the following MA disability services:

- Adult companion services
- Chore services
- Homemaker services
- Day support services
- Family training and counseling under a disability waiver
- Community residential services one-to-one staffing
- Independent living skills
- Individualized home supports with training
- Individualized home supports with family training
- Individualized home supports
- Home-delivered meals
- Personal emergency response system
- Respite services
- Overnight supervision services
- Transportation services

Provides an immediate effective date.

**19 Payment for customized living.**

Amends § 256B.4914, subd. 6d. Requires customized living monthly service rate limits under the disability waiver rate system (DWRS) to align with monthly service rate limits determined under elderly waiver customized living services.

**20 Documentation of staffing; auditing and rate review.**

Amends § 256B.4914, by adding subd. 10e. Effective for services provided on or after January 1, 2029, requires residential support services providers reimbursed under DWRS to maintain documentation of direct staffing hours provided to each person receiving services and specifies the information that must be included in the documentation. Requires providers to maintain documentation for at least six years and to submit documentation to the commissioner annually. Requires the commissioner to conduct periodic analysis of documentation and allows the commissioner to validate staffing data through random audits or other verification methods. Allows the commissioner to provide recommendations to lead agencies regarding modifications to the rate of a person receiving services. Specifies the commissioner's sanction authority for a provider who fails to submit requested

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documentation within the submission window. Requires the commissioner to publish annual aggregate reports summarizing audit findings and trends related to staffing.

Provides an immediate effective date.

**21 Integrated community supports setting approval moratorium and exception.**

Amends § 256B.492, by adding subd. 4. Defines “integrated community supports setting” in the section of statutes governing home and community-based settings for people with disabilities. Prohibits the commissioner from approving a new integrated community supports setting or approving an expansion of an existing integrated community supports setting. Allows the commissioner to approve exceptions to the moratorium if specified conditions are met. Requires priority for exceptions to be given to geographic regions with insufficient integrated community supports capacity based on statewide or regional needs determination processes. Specifies a determination under this subdivision is final and not subject to appeal.

Provides a January 1, 2027, effective date.

**22 Customized living and 24-hour customized living moratorium.**

Amends § 256S.20, by adding subd. 6. Establishes a moratorium on new customized living or 24-hour customized living settings and on new provider enrollment to provide customized living or 24-hour customized living services. Allows the commissioner to approve exceptions to the moratorium under specified circumstances. Specifies a determination under this subdivision is final and not subject to appeal.

Provides a January 1, 2027, effective date.

**23 Documentation of staffing; auditing and rate review for residential support services.**

Amends § 256S.21, by adding subd. 4. Effective for services provided on or after January 1, 2029, requires residential support services providers reimbursed under the elderly waiver to maintain documentation of direct staffing hours provided to each person receiving services and specifies the information that must be included in the documentation. Requires providers to maintain documentation for at least six years and to submit documentation to the commissioner annually. Requires the commissioner to conduct periodic analysis of documentation and allows the commissioner to validate staffing data through random audits or other verification methods. Allows the commissioner to provide recommendations to lead agencies regarding modifications to the rate of a person receiving services. Specifies the commissioner’s sanction authority for a provider who fails to submit requested

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documentation within the submission window. Requires the commissioner to publish annual aggregate reports summarizing audit findings and trends related to staffing.

Provides an immediate effective date.

**24 Market rate study for home and community-based services.**

Requires the commissioner of human services to: (1) conduct a market rate study to evaluate the adequacy, sustainability, and equity of payment rates for specific home and community-based services under the MA disability waivers. Lists the services and items the study must analyze; (2) consult with interested parties in planning and conducting the study; (3) analyze provider costs, workforce availability, wage competitiveness, regional market conditions, inflationary impacts, and access issues in conducting the study; and (4) by February 15, 2027, submit a report with findings and recommendations to the legislature.

Provides an immediate effective date.

**25 Waiver case management advisory working group.**

Establishes the waiver case management advisory working group.

**Subd. 1. Establishment; purpose.** Requires the commissioner of human services to convene a waiver case management advisory working group to evaluate and make recommendations regarding the quality, workforce sustainability, accountability, and long-term stability of waiver case management services.

**Subd. 2. Membership.** Lists the individuals and organizations that must be represented in the working group.

**Subd. 3. Compensation; expenses.** Allows members of the working group to receive compensation and expense reimbursement as provided in the statute governing advisory councils and committees.

**Subd. 4. Meetings; administrative support.** Specifies when the first meeting of the working group must be convened and how often the working group must meet. Makes working group meetings subject to the Open Meeting Law. Allows the working group to meet by telephone or interactive technology. Requires the Department of Human Services to provide staff and administrative support for the working group.

**Subd. 5. Duties.** Lists the duties of the working group, including: (1) examining accountability and oversight mechanisms and grievance processes across delivery models; and (2) reviewing available data related to workforce vacancies, turnover, compensation, and service access.

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**Subd. 6. Report.** By September 1, 2027, requires the commissioner to submit a report of the working group's findings and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance.

**Subd. 7. Expiration.** Makes the working group expire upon submission of the report required under subdivision 6.

Provides a July 1, 2026, effective date.

**26 Direction to commissioner; HCBS waiver case management evaluation and report.**

Requires the commissioner of human services to: (1) evaluate reimbursement rates and lead agency duties associated with home and community-based services case management; (2) develop an updated payment methodology for waiver case management; (3) consult with interested parties; and (4) by December 15, 2028, submit a report to the legislature with findings and recommendations. Allows the commissioner to contract with rate experts to develop and model recommended rates. Lists the information the report must include.

Provides a July 1, 2027, effective date.

**27 Integrated community supports reform study.**

**Subd. 1. Review and evaluation.** Requires the commissioner of human services to review the MA integrated community supports (ICS) service provided under the disability waivers and evaluate the need for statutory, regulatory, and programmatic reforms. Lists the information that must be included in the evaluation.

**Subd. 2. Stakeholder consultation.** Requires the commissioner to consult with stakeholders in conducting the review of ICS services and lists the stakeholders who must be consulted.

**Subd. 3. Report.** Requires the commissioner to develop recommendations for legislative and administrative changes to strengthen the ICS program and to submit a report to the legislature by September 1, 2027.

**28 MnCHOICES redesign working group.**

Establishes a MnCHOICES redesign working group to develop recommendations related to state provision of MnCHOICES assessments.

**Subd. 1. Establishment.** Requires the commissioner of human services to convene a MnCHOICES redesign working group to develop recommendations related to state provision of MnCHOICES assessments.

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**Subd. 2. Membership.** Lists the members the working group must include.

**Subd. 3. Duties.** Requires the working group to make recommendations to shift the responsibility and administration of conducting MnCHOICES assessments to the state. Lists items the recommendations must include.

**Subd. 4. Terms, compensation, and removal.** Specifies the terms, compensation, and removal of working group members are governed by the advisory councils and committees section of statutes.

**Subd. 5. Meetings; administrative support.** Specifies when the first meeting of the working group must be convened and how often the working group must meet. Makes working group meetings subject to the Open Meeting Law. Allows the working group to meet by telephone or interactive technology. Requires the Department of Human Services to provide staff and administrative support for the working group.

**Subd. 6. Report.** By September 1, 2027, requires the commissioner to submit a report of the working group's findings and recommendations to the legislature.

**Subd. 7. Expiration.** Makes the working group expire upon submission of the report required under subdivision 6.

29 **Repealer.**

Repeals Minn. Stat. § 256B.073, subd. 4 (electronic visit verification; provider requirements).

Provides a July 1, 2026, effective date.

## **Article 7: Miscellaneous**

This article modifies provisions governing MA fraud, provides the attorney general with subpoena and enforcement authority, provides for criminal penalties, makes additional parties eligible for cost and fee awards in civil actions and contested cases involving the state, modifies requirements for assisted living facilities to provide residents with a way to request assistance for health and safety needs, adds assisted living facilities to the health care facilities exempt from the provider tax, and requires the commissioner of human services to conduct a study to assess roles and responsibilities in administering human services programs.

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**1 Authority.**

Amends § 8.16, subd. 1. Expands the authority of the attorney general to issue subpoenas in ongoing legitimate law enforcement investigations to include wage and employment records, insurance records related to claim settlement, and the financial records of the subject of an investigation into suspected public benefit fraud.

**2 Party.**

Amends § 15.471, subd. 6. Under current law if a party other than the state prevails in a civil action or contested case involving the state and shows the state's position was not substantially justified, the prevailing party must be awarded fees and expenses. To be eligible for fees and expenses, under current law a party must not have annual revenue of more than \$7,000,000; this section increases the annual revenue limit to \$13,500,000. Also makes an entity licensed by the Department of Health eligible to be awarded fees and expenses for a matter that involves licensing; under current law these entities are excluded from the definition of "party."

**3 Minimum requirements.**

Amends § 144G.41, subd. 1. Modifies the requirement for assisted living facilities to provide residents with a way to request assistance with health and safety needs 24 hours per day, seven days per week, to allow a facility to use person-centered strategies to provide residents with a means to request assistance and allows the use of technological devices to request assistance.

**4 Alternative to summoning device to request assistance.**

Adds subd. 1c to § 144G.41. Specifies a facility is not required to have a resident use a summoning device to request assistance for health and safety needs, and requires a facility to use person-centered strategies to meet a resident's needs, for a resident who cannot reliably use a summoning device to request assistance.

**5 Legal representation.**

Amends § 256B.12. Makes a conforming change in the section authorizing the attorney general or a county attorney to initiate a criminal or civil action related to medical assistance fraud and other theft offenses.

**6 Health care provider.**

Amends § 295.50, subd. 4. In a paragraph listing facilities and providers not included in the definition of health care provider for purposes of the provider tax, removes an obsolete reference to housing with services establishment and adds assisted living facilities to the facilities not required to pay the provider tax. (The facility category housing with services establishment was eliminated in 2021, and facilities that wanted to continue providing housing and services were required to become licensed as assisted living facilities. Exempting assisted living facilities from being

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required to pay the provider tax conforms with the Department of Revenue's current administration of the provider tax.)

**7 Patient services.**

Amends § 295.50, subd. 9b. In a paragraph listing services not included in the definition of patient services for purposes of the provider tax, removes an obsolete reference to housing with services establishments and adds services provided by assisted living facilities to the services excluded from patient services.

**8 Medical assistance fraud.**

Creates § 609.467.

**Subd. 1. Medical assistance fraud prohibited.** Establishes that a person can commit medical assistance fraud by committing any of eight acts:

- 1) obtaining medical assistance funds through some sort of false representation made with the intent to defraud;
- 2) making a claim for reimbursement while knowing that any part of the claim is ineligible for reimbursement;
- 3) providing false information on an enrollment application, provider agreement, or ownership disclosure;
- 4) owning or operating an entity that receives medical assistance funds while being prohibited from enrolling as a provider;
- 5) knowingly allowing someone else to own or operate an entity that receives medical assistance funds while the other person is prohibited from enrolling as a provider;
- 6) falsely making or altering a record related to the delivery of medical assistance services;
- 7) submitting a claim for personal care assistance services or CFSS knowing that services were not provided; or
- 8) destroying records that are required to be retained under chapter 256B or 245A, or rules adopted pursuant to those chapters, after receiving a lawful request to produce them.

**Subd. 2. Penalties.** Establishes penalties for a violation of subdivision 1. Provides that the maximum prison sentence for a violation is ten years unless one of the greater penalties applies. Establishes that the maximum prison sentence is 20 years if the violation causes a loss of more than \$100,000 but not more than \$1,000,000. Provides that the maximum prison sentence is 30 years if the violation causes a loss in excess of \$1,000,000.

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**Subd. 3. Failure to keep or maintain medical assistance records.** Establishes a gross misdemeanor penalty if a person intentionally fails to maintain medical, health care, and financial records as required under chapter 256B or 245A, or rules adopted pursuant to those chapters.

**Subd. 4. Continuing offense.** Establishes that a violation of subdivision 1 or 3 is a continuing offense for the purpose of calculating whether the statute of limitations has expired.

**Subd. 5. Venue.** Establishes that a violation may be prosecuted in any county where the offense occurred or any county where the entity that received a claim for payment is located.

**Subd. 6. Restitution.** Authorizes a court to order restitution for similar acts that are related to the offense, but were not charged. Allows an offender to challenge restitution and directs the court to make a determination based on a preponderance of the evidence. Establishes that the burden of proof is on the prosecutor.

**9 Acts constituting theft.**

Amends § 609.52, subd. 2. Makes a conforming change to remove a portion of the theft statute that is replaced by the new medical assistance fraud crime.

**10 Criminal act.**

Amends § 609.902, subd. 4. Amends the definition of “criminal act” in the statutes addressing racketeer influenced and corrupt organizations (RICO) violations to include medical assistance fraud.

**11 Limitations.**

Amends § 628.26. Makes a conforming change in the statute establishing statutes of limitations for criminal offenses.

**12 Direction to commissioner; assessment of administration roles.**

Requires the commissioner of human services, in consultation with Tribal Nations and counties, to conduct a study to assess and recommend improvements to roles and responsibilities of the state agency, counties, and Tribal Nations in administering human services programs. Lists the items the study must evaluate. Requires the study to focus on the goals of transforming the human services system to ensure a transparent, accessible, accountable, equitable, and effective human services system. Lists items that must be included in the recommendations. By October 1, 2028, requires the commissioner to submit a report on the study to the legislature.

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**13 Repealer.**

Repeals section 609.466, the crime of medical assistance fraud, which is replaced with a new offense in section 8.

**Article 8: Department of Human Services Appropriations**

This article contains adjustments to fiscal year 2027 appropriations for the Department of Human Services for the central office, housing support, MA, alternative care, and the behavioral health fund.

**Article 9: Other Agency Appropriations**

This article contains adjustments to fiscal year 2027 appropriations for the attorney general's office and the Department of Children, Youth, and Families.



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