..... moves to amend H.F. No. 729, the delete everything amendment (H0729DE2), as follows:

Page 32, after line 6, insert:

"ARTICLE 4

MEDICAL ASSISTANCE PROVIDER ENROLLMENT

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

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

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

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

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

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

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

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

(b) Controlling individual does not include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Controlling individual does not include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) unannounced site visits, as follows:

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

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

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

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

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

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

(1) the provider fails to demonstrate financial viability;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) if a provider fails to submit all required materials or satisfy the requirements of paragraph (b) by the due date, notify the provider of the deficiency within 14 days after the

due date and allow the provider an additional 14 days from the notification date to comply; and

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

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

(c) A provider must demonstrate financial capacity, as described under subdivision 7, as a requirement of revalidation under this subdivision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) serves primarily a pediatric population.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 2. **Providers licensed by the commissioner of human services.** An enrolled provider that is licensed by the commissioner under chapter 245A must designate an individual as the licensee's compliance officer under section 256B.044, subdivision 8, paragraph (b).

Subd. 3. **Providers licensed by the commissioner of health.** An 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 officer under section 256B.044, subdivision 8, paragraph (b).

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

Subd. 4. **Provider payment rates.** (a) Payment rates for participating providers must be increased for services provided to medical assistance enrollees. To receive a rate increase, participating providers must meet demonstration project requirements and provide evidence of formal referral arrangements with providers delivering step-up or step-down levels of care. Providers that have enrolled in the demonstration project but have not met the provider standards under subdivision 3 as of July 1, 2022, are not eligible for a rate increase under this subdivision until the date that the provider meets the provider standards in subdivision 3. Services provided from July 1, 2022, to the date that the provider meets the provider standards under subdivision 3 shall be reimbursed at rates according to section 254B.0505, subdivision 1. Rate increases paid under this subdivision to a provider for services provided between July 1, 2021, and July 1, 2022, are not subject to recoupment when the provider is taking meaningful steps to meet demonstration project requirements that are not otherwise

required by law, and the provider provides documentation to the commissioner, upon request, of the steps being taken.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) provide training for all agency staff on the requirements and responsibilities listed in the Maltreatment of Minors Act, chapter 260E, and the Vulnerable Adult Protection Act,

section 626.557, including mandated and voluntary reporting, nonretaliation, and the agency's policy for all staff on how to report suspected abuse and neglect;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) EIDBI provider qualifications under this section;

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

(3) EIDBI provider or agency standards or requirements.

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

Renumber the articles in sequence and correct the internal references

Amend the title accordingly