Act Summary

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Subject Human Services Supplemental Budget Bill

Bill S.F. 4476

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Overview

This act contains human services provisions related to continuity of care, long-term care facility regulation, health care, the Department of Human Services (DHS) Office of Inspector General, background studies, behavioral health, uniform service standards, aging and disability services, electronic visit verification, other miscellaneous provisions, and appropriations for DHS and other agencies.

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Article 1: Continuity of Care

This article contains provisions related to providing for continuity of care under medical assistance (MA) when providers of certain services are subject to an administrative action or experiencing a serious operational event, providing for complex transitions, establishing housing support capacity-building grants, and directing the commissioner of human services to develop continuity of care policies and procedures.

Section	Description - Article 1: Continuity of Care

1 **Continuity of care.**

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 continuity of care and complex transitions, defines the following terms:

- Administrative action
- Complex transition
- 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. Lead agency duties. Lists lead agency duties when a provider is subject to an administrative action or serious operational event.

Subd. 4. Commissioner's duties. Lists the commissioner's duties when the commissioner takes an administrative action against a provider. Requires the commissioner to establish and maintain a continuity of care team to support continuity of care efforts by lead agencies and providers, specifies the personnel who must be included on the continuity of care team, and specifies the duties of the continuity of care team.

2 **Complex transitions.**

Creates § 256B.046.

Subd. 1. Complex transition identification. Requires the lead agency to work with the provider and commissioner to identify each recipient whose transition is a complex transition. Requires the lead agency and provider to submit to the

Section	Description - Article 1: Continuity of Care

commissioner a complex transition plan for each recipient identified. Allows the commissioner to establish objective thresholds to create a presumption of complex transition based on specified criteria.

Subd. 2. Complex transition plan. Requires the commissioner to develop guidance on effective complex transition planning and make a complex transition plan template available to providers and lead agencies. Specifies the information that must be included in the plan template. Requires providers and lead agencies to use the plan template to develop a complex transition plan for each recipient whose transition is identified as a complex transition.

Subd. 3. Complex transition planning. Requires a lead agency that receives a notice from a provider of a serious operational event, or notice from the commissioner of an administrative action taken against a provider, to assist a recipient with an identified complex transition to develop a complex transition plan through a person-centered process. Specifies timelines for developing the complex transition plan and the information that must be included in the plan. Requires the lead agency to convene a meeting of specified individuals and entities to discuss implementation of the complex transition plan.

Subd. 4. No alternative services notification. Requires the lead agency to notify the commissioner if the lead agency does not identify an alternative service option, setting, or provider, or safe and stable housing option. Specifies commissioner's duties upon receiving notification from a lead agency that the lead agency has failed to arrange for an alternative service option, setting, or provider, or safe and stable housing option.

Subd. 5. Publishing data on continuity of care planning and complex transitions. Lists data the commissioner must maintain on the DHS website related to continuity of care planning and complex transitions and requires the commissioner to include functionality to filter data by region or county, provided the filtering functionalities comply with federal and state laws regarding the protection of personal health information and personally identifiable information.

3 **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 an administrative action or a serious operational event.

Section	Description - Article 1: Continuity of Care
4	**Duties when a provider is no longer able to provide services.** Amends § 256B.69, by adding subd. 38. Lays out managed care and county-based purchasing plan duties when a provider is subject to a serious operational event or administrative action.
5	**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 an administrative action or a serious operational event.
6	**Housing support capacity-building grants.** Requires the commissioner to establish capacity-building grants for housing support providers assisting MA home and community-based services recipients to prevent homelessness and institutionalization. Specifies eligible recipients. Lists allowable uses of capacity-building grant money. Lists data grant recipients must report to the commissioner. Provides a July 1, 2026, effective date.
7	**Direction to commissioner; continuity of care policies and procedures.** Requires the commissioner of human services to develop policies and procedures lead agencies must follow when developing, implementing, monitoring, and closing a complex transition plan. Specifies the information and documentation requirements that must be included in the policies and procedures.

Article 2: Long-Term Care Facility

This article makes appropriations for the home and community-based services employee scholarship and loan forgiveness program available until expended; modifies a subdivision governing maximum fees charged by the Board of Executives for Long-term Services and Supports; exempts federally qualified health centers that provide nursing care from being required to obtain a home care provider license; modifies provisions relating to licensure, relocation, and inspection of assisted living facilities with capacities of five or fewer or six or fewer; and requires the commissioner of health to develop a new licensure category for assisted living facilities with a capacity of five or fewer.

Section	Description - Article 2: Long-Term Care Facility
1	**Selection process.** Amends § 144.1503, subd. 7. Provides that appropriations for the home and community-based services employee scholarship and loan forgiveness program do not cancel and are available until expended.
2	**Amounts.** Amends § 144A.291, subd. 2. In a subdivision governing the maximum fees charged by the Board of Executives for Long-term Services and Supports, specifies the fee for an application for initial licensure as a nursing home administrator, assisted living director, or health services executive is $250 regardless of when the license is issued in the calendar year; specifies the fees for license renewal or a duplicate license also apply to certificate renewal or a duplicate permit or certificate; and makes other technical changes.
3	**Exemptions from home care services licensure.** Amends § 144A.471, subd. 8. Provides that a federally qualified health center providing part-time or intermittent nursing care in an area with a shortage of home health agencies is not required to be licensed as a home care provider under chapter 144A. Effective date: day following final enactment.
4	**Consideration of applications.** Amends § 144G.15. Lists criteria the commissioner of health must consider before issuing a provisional license for an assisted living facility with a capacity of six or fewer. Prohibits the commissioner from granting a provisional license for an assisted living facility with a capacity of six or fewer until the commissioner of human services determines the facility's proposed location meets location standards in chapter 245A for certain home and community-based residential settings and programs (these standards prohibit certain newly licensed residential settings and programs from being located on the same property as or on an adjoining property to an existing residential setting or program).
5	**Notice to affected municipality.** Adds subd. 8 to § 144G.16. Requires the commissioner to provide notice to an affected municipality or other political subdivision within five days after issuing a provisional license to an assisted living facility with a capacity of six or fewer, lists information the notice must include, and permits the notice to be provided through electronic communication or a written document. Effective date: July 1, 2026, and applies to provisional licenses issued on or after that date.

Section	Description - Article 2: Long-Term Care Facility

6 **New license not required.**

Amends § 144G.195, subd. 1. Modifies requirements governing the relocation of assisted living facilities with a capacity of five or fewer, to:

- require the commissioner of health to ask the commissioner of human services to determine whether a facility's new location meets location standards in chapter 245A for certain home and community-based residential settings and programs;
- direct the commissioner of health to approve or deny the license relocation after inspecting the building and receiving a determination from the commissioner of human services on the facility's new location;
- establish separate relocation standards for facilities in the seven-county metro area and facilities outside the seven-county metro area;
- clarify that all provisions in section 144G.195 apply when a facility notifies the commissioner of its intent to move to an alternative location; and
- require the commissioner of health to notify the affected municipality if the commissioner approves a relocation.

7 **Local laws apply; delegating inspection authority.**

Amends § 144G.45, subd. 3. At the request of a county or local unit of government, allows the commissioner to delegate to the county or local unit of government, authority to inspect existing assisted living facilities with a capacity of six or fewer for compliance with physical plant requirements and zoning ordinances. If authority is delegated, requires the commissioner to execute a formal delegation of authority that addresses the listed topics. When conducting an inspection under delegated authority, requires the county or local unit of government to provide the subject of the inspection with a copy of the delegation. Requires entities with delegated authority to coordinate inspections with the commissioner and to notify the commissioner of violations or concerns, and specifies the frequency of inspections by an entity with delegated authority. Requires the commissioner to ensure that laws, rules, and codes are uniformly enforced throughout the state and to ensure entities with delegated authority have sufficient expertise to conduct delegated inspections.

Effective date: January 1, 2027.

8 **Direction to commissioner of health; small assisted living facility licensure.**

Requires the commissioner to convene a group to examine the licensing requirements for assisted living facilities with a capacity of five or fewer; develop a new licensing category for these facilities; develop legislation to establish a new license category for these facilities; and submit the draft legislation to the chairs and

Section	Description - Article 2: Long-Term Care Facility
	ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 1, 2028.

Article 3: Health Care

This article makes changes to the requirements governing health care provider enrollment in MA, establishes prepayment and postpayment review of MA claims, and allows the commissioner of DHS to establish MA provider enrollment moratoria in specified circumstances. The article also makes changes for federal compliance related to targeted case management, reorganizes the statute governing MA sanctions, clarifies the applicability of related statutes, allows for administrative review of temporary payment withholding or reduction actions, and adds required compliance training for high-risk MA provider types.

Section	Description - Article 3: Health Care
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	**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.
3	**Case management contact.** Amends § 245.462 by adding subd. 2a. Defines “case management contact” in the Adult Mental Health Act.
4	**Coordination between case manager and community support services.** Amends § 245.4711, subd. 5. Requires a case manager to have at least one case management contact per month, with a documented core service component, to claim reimbursement for adult mental health targeted case management. Prohibits case management contact by telephone for more than two consecutive months.
5	**Coordination between case manager and family community support services.** Amends § 245.4881, subd. 5. Requires a case manager to have at least one case management contact per month with the child, the child's parents, or the child's legal representative.

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6	**Controlling individual.** Amends § 245A.02, subd. 5a. Updates a cross-reference related to the recodification of section 256B.04, subdivision 21.
7	**Application for licensure.** Amends § 245A.04, subd. 1, as amended by Laws 2026, ch. 88, art. 1, § 101. Specifies that a license issued pursuant to a change of ownership under section 245A.043 is not subject to any licensing moratorium if the change of ownership does not result in an increase in licensed capacity or service scope. 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.
8	**Grant of license; license extension.** Amends § 245A.04, subd. 7. Makes technical conforming change.
9	**Department of Human Services home and community-based services early and often licensor and compliance team.** Amends § 245A.042 by adding subd. 7. Requires the commissioner to establish and maintain a home and community-based services early and often licensor and compliance team, to deliver support to applicants through the application process and to license holders during the first year of operation. Specifies additional requirements for the compliance team. Allows the compliance team to issue a licensing and compliance review report containing recommendations, if the team finds that the license holder has failed to achieve compliance with an applicable law, rule, or regulation, and the failure does not imminently endanger the health, safety, or rights of persons served by the program.
10	**Denial of application.** Amends § 245A.05. Makes technical conforming change.
11	**Program management and oversight.** Amends § 245D.081, subd. 3. Updates a cross-reference related to the recodification of section 256B.04, subdivision 21.

Section	Description - Article 3: Health Care
12	**Specific powers.** Amends § 256.01, subd. 2. Provides that the responsibilities of the commissioner of human services for ensuring the detection, prevention, investigation, and resolution of fraudulent activities include the use of a preenrollment risk assessment for health care providers and agencies conducted in accordance with section 256B.0437.
13	**Department of Human Services home and community-based services provider support and technical assistance team.** Amends § 256.01 by adding subd. 46. Requires the commissioner to establish and maintain a home and community-based services provider support and technical assistance team to support home and community-based services providers. Lists additional requirements for the team.
14	**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.
15	**Provider enrollment.** Amends § 256B.04, subd. 21, as amended by Laws 2026, ch. 95, art. 4, § 12. Strikes the requirements related to MA provider enrollment. Much of the stricken language is recodified under this act.
16	**Medical assistance education program.** Adds a subdivision to § 256B.04. Directs the commissioner of human services 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 enrollees who receive case management services or have a support plan, the information must be tailored to the enrollees' service needs.
17	**Preenrollment assessment.** Creates § 256B.0437. Paragraph (a) permits the commissioner of human services to complete a preenrollment risk assessment on a health care provider or agency prior to enrolling the provider or agency in MA. Requires that the commissioner use a risk-score framework as a component of any assessment.

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Paragraph (b) allows the commissioner to deny or rescind a provider's or agency's enrollment based on the results of the preenrollment risk assessment. Provides for notification of a decision to deny or rescind enrollment and allows applicants to request reconsideration.

Paragraph (c) requires that a provider enrolled before July 1, 2026, that billed for services on or after January 1, 2025, must receive a positive reenrollment risk assessment no later than July 1, 2027, to remain enrolled in MA. A provider or agency enrolled before July 1, 2026, that has not billed for services on or after January 1, 2025, must receive a positive assessment no later than July 1, 2026, to remain enrolled. Allows a provider that becomes ineligible under this paragraph to regain eligibility after receiving a positive assessment.

18 **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. Makes a provider's failure to submit the information required for a background study under this subdivision ground for denial or termination of enrollment in MA. 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 enroll each provider-controlled location where direct services are provided as a condition of enrolling in MA, with some exceptions. Defines "provider-controlled location." Makes a provider's failure to enroll locations as required under this subdivision grounds for sanctions under section 256B.064. This is a recodification of part of section 256B.04, subdivision 21, paragraph (a), with substantive modifications.

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Subd. 5. Site visits. Requires that moderate-risk and high-risk 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. Directs the commissioner to conduct unannounced site visits of all a provider's locations prior to enrolling, reenrolling, and revalidating a provider that is designated moderate-risk or high-risk. This is a recodification of part of section 256B.04, subdivision 21, paragraph (j).

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. Provides that the surety bond must name DHS as an obligee, be purchased new annually, and allow for recovery of costs and fees in pursuing a claim on the bond. Provides that 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 final agency decision. Makes the section inapplicable to a provider that currently maintains a surety bond under other sections of chapter 256B. This is a recodification of section 256B.04, subdivision 21, paragraph (m), with substantive modifications.

Subd. 7. Financial capacity. Requires a provider to attest to sufficient financial capacity to operate, in a form and manner prescribed by the commissioner of human services, 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. Permits 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).

Subd. 10. Correspondence and notification. Allows the commissioner to 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).

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19 **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 moderate-risk or high-risk 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 recodification of section 256B.04, subdivision 21, paragraph (c), with substantive modifications.

20 **Provider enrollment suspension and terminations.**

Creates § 256B.0442.

Subd. 1. Suspension of billing privileges. Allows the commissioner to suspend a provider's ability to bill if the provider is not in compliance with program requirements or when necessary to protect public funds or ensure program integrity. Provides that the suspension must be in place until the provider comes into compliance. Notes that a suspension under this subdivision does not limit the authority of the commissioner to issue any other sanction allowed under federal or state law. Provides that the commissioner's decision to suspend a provider's ability to bill is not subject to an administrative appeal. 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

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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).

Subd. 4. Termination for lack of submitted claims. Allows the commissioner to terminate the enrollment of a provider if the provider has not submitted any claims in the previous 12 consecutive calendar months. This is new language.

21 **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).

22 **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.

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. Provides that the commissioner must notify the legislature within 60 days of ending an enrollment moratorium about the results of the moratorium.

23 **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

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equipment. This is a recodification of section 256B.04, subdivision 21, paragraph (l), with some substantive modifications.

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).

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

Subd. 2. Mandatory compliance training. 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.

25 **Enhanced prepayment review.**

Creates § 256B.0447.

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Subd. 1. Purpose and authority. Provides that the commissioner of human services must conduct prepayment review of submitted fee-for-service (FFS) MA claims.

Subd. 2. Review requirement. Requires that beginning April 1, 2027, the commissioner must conduct prepayment review under this section of at least 65 percent of all FFS claims.

Subd. 3. Notice. Requires that the commissioner give providers written notice of being subject to prepayment review at least 15 days before the review is implemented, but allows the commissioner to delay, limit, or withhold the notice if providing the notice would compromise program integrity, prejudice an audit or investigation, or conflict with federal law or guidance.

Subd. 4. Continued enrollment of new clients. Provides that nothing in this section prohibits an enrolled provider that is subject to prepayment review from enrolling new clients or beneficiaries during the period of review.

Subd. 5. Timely claims processing. Directs the commissioner to conduct prepayment review in a manner consistent with federal regulations governing timely processing of MA claims.

Subd. 6. Relationship to other actions. Provides that conducting prepayment review does not preclude the commissioner from taking other investigatory actions or imposing sanctions as allowed under state or federal law.

Subd. 7. Information on website. Directs the commissioner to publish, at least annually, information about conducting prepayment review on the DHS website.

Makes the section effective January 1, 2027.

26 **Postpayment review.**

Creates § 256B.0448.

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

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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.

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 the section effective January 1, 2027.

27 **Transportation costs.**

Amends § 256B.0625, subd. 17. For nonemergency medical transportation (NEMT) under MA, modifies multiple expiration dates in paragraphs to provide that the paragraphs expire upon implementation of the single NEMT administrator (rather than on a specified date).

Makes the section effective immediately.

28 **Administration of nonemergency medical transportation.**

Amends § 256B.0625, subd. 18i. Makes the requirement for the commissioner to contract with a single NEMT administrator under MA effective July 1, 2026. Directs the commissioner to provide six months' notice to counties, managed care organizations, and county-based purchasers before implementing the single NEMT administrator.

Makes the section effective immediately.

29 **Mental health case management.**

Amends § 256B.0625, subd. 20. Modifies MA reimbursement eligibility for mental health case management. Requires an entity to document the following in order to be eligible for MA reimbursement:

- face-to-face contacts with the recipient;
- telephone contacts with specified individuals;
- face-to-face contacts with specified individuals;
- contacts between the case manager and the case manager's clinical supervisor about the recipient;
- individual community support plan and assessment development, review, and revision; and

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- travel time for face-to-face meetings.

Specifies that travel time is eligible for payment if the individual with whom the case manager has scheduled a meeting does not attend the meeting.

Allows counties to receive payment for up to 12 15-minute units for use at case initiation and case closing for specified tasks, without needing to meet statutory contact requirements. Makes technical and clarifying changes.

30 **Sanctions available.**

Amends § 256B.064, subd. 1b. Adds paragraph lettering; numbers lists; updates terminology.

Provides an immediate effective date.

31 **Grounds for and methods of monetary recovery.**

Amends § 256B.064, subd. 1c. Updates terminology.

Provides an immediate effective date.

32 **Investigative costs.**

Amends § 256B.064, subd. 1d. Adds paragraph lettering; updates terminology.

Provides an immediate effective date.

33 **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.

Provides an immediate effective date.

34 **Imposition of fines.**

Amends § 256B.064 by adding subd. 2a. Adds new subdivision with language formerly in subdivision 2, paragraphs (g) and (h).

Provides an immediate effective date.

35 **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).

Provides an immediate effective date.

Section	Description - Article 3: Health Care
36	**Imposition of withholding or reduction of payments without prior notice.** Amends § 256B.064 by adding subd. 2c. Adds new subdivision with language formerly in subdivision 2, paragraphs (b), (c), and (d). Modifies what constitutes a credible allegation of fraud by adding criteria. Provides an immediate effective date.
37	**Administrative review of temporary payment withhold or reduction.** Amends § 256B.064 by adding subd. 2d. Allows an individual or entity to request an administrative review of a temporary payment withhold or reduction; specifies requirements and contents for the review request. Requires the commissioner to refer the review request to the Court of Administrative Hearings within ten business days of receiving the request, and specifies that costs for a review must be borne equally by both sides. Specifies that the review is limited to whether the commissioner can establish that there is a credible allegation of fraud against the individual or entity. Requires evidence to be submitted to the administrative law judge under seal, and requires the judge to review the evidence in private. Specifies that the commissioner is not subject to discovery during review proceedings. Outlines requirements for notifications when the administrative law judge completes the recommendation. Specifies that the judge's findings of facts, conclusions of law, and recommendation are not binding or conclusive, and must not be used or considered for any other purpose or proceeding.
38	**Withholding or reduction of payments; review.** Amends § 256B.064 by adding subd. 2e. For a temporary payment withhold or reduction in effect after 90 days, requires the commissioner to submit evidence to an administrative law judge under seal, for the judge to determine whether the commissioner or a law enforcement agency is actively pursuing an investigation of the individual or entity. Requires the administrative law judge to review the evidence in private and make a recommendation on continuing the payment withholding or reduction. Specifies that the recommendation is advisory, and that the commissioner's decision to continue a withholding or reduction is final and not subject to appeal. Requires this review every 90 days, for each payment withhold or reduction; requires notice to the individual or entity within ten business days of the completion of each 90-day review.

Section	Description - Article 3: Health Care
39	**Judicial review.** Amends § 256B.064 by adding subd. 2f. Specifies that administrative law judge findings of facts, conclusions of law, and recommendations under this section are not subject to judicial review.
40	**Forfeiture of withheld payments upon criminal conviction.** Amends § 256B.064 by adding subd. 2g. Adds new subdivision with language formerly in subdivision 2, paragraph (d). Provides an immediate effective date.
41	**Mandates on prohibited payments.** Amends § 256B.064, subd. 3. Updates terminology and cross-references. Provides an immediate effective date.
42	**Notice.** Amends § 256B.064, subd. 4. Updates terminology and cross-references. Provides an immediate effective date.
43	**Immunity; good faith reporters.** Amends § 256B.064, subd. 5. Updates terminology. Provides an immediate effective date.
44	**Application.** Amends § 256B.064 by adding subd. 6. Specifies that section 256B.064 supersedes any inconsistent or contrary provision of law. Provides an immediate effective date.
45	**Coordination with law enforcement.** Amends § 256B.064 by adding subd. 8. Requires the commissioner to coordinate with appropriate law enforcement authorities when a temporary withholding or reduction of payments involves potential criminal conduct.
46	**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

Section	Description - Article 3: Health Care

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.

47 **Provider qualifications and duties.**

Amends § 256B.0701, subd. 9, as amended by Laws 2026, ch. 95, art. 4, § 15. Updates a cross-reference related to the recodification of section 256B.04, subdivision 21.

48 **Generally.**

Amends § 256B.076, subd. 1. Adds citations to targeted case management medical assistance coverage. Adds paragraph (c), to allow the commissioner to suspend, reduce, or terminate reimbursement to a provider that does not meet statutory requirements. Specifies that the county of financial responsibility or Tribal agency is responsible for any federal disallowances.

49 **County-provided fee-for-service rate setting and reconciliation.**

Amends § 256B.076 by adding subd. 5. Paragraph (a) requires the commissioner to pay targeted case management services for which counties provide the nonfederal share of money and county staff provide the services, on a fee-for-service basis according to a cost-based payment methodology. Requires payments to be consistent with federal regulations related to certified public expenditures. Requires a county providing eligible services to complete a federally approved cost report in order to receive federal reimbursement.

Paragraph (b) requires the commissioner to reimburse submitted claims based on an interim rate, and to determine a final rate after completing cost report reconciliation, notify counties of the final rate, and post final rates publicly.

Paragraph (c) outlines how a county may repeal a final rate determined by the commissioner.

Paragraph (d) specifies that the payment methodology must only be used to reimburse allowable MA costs, and that the county is responsible for any federal disallowances.

Paragraph (e) requires the commissioner to base interim rates on data from the testing period, and to base subsequent interim rates on the most recently completed reconciliation. Outlines requirements for notification and publication of interim rates.

Paragraph (f) specifies that payments to counties for targeted case management expenditures must be made only from federal earnings from services provided.

Section	Description - Article 3: Health Care

Paragraph (g) requires counties to submit all claims under this section using 15-minute billing units.

Provides an immediate effective date.

50 **Testing and implementation.**

Amends § 256B.076 by adding subd. 6. Requires the commissioners of human services and children, youth, and families, the Association of Minnesota Counties, and the Minnesota Association of County Social Service Administrators to establish a joint governance agreement related to the provision of targeted case management services. Specifies requirements for the joint governance agreement.

51 **Managed care plan units and rates for mental health targeted case management.**

Amends § 256B.076 by adding subd. 7. Requires the commissioner to ensure that the prepaid health plans providing covered health services reimburse counties for targeted case management services at a rate that is at least equal to the fee-for-service rate for such services. Outlines additional administrative and contract requirements.

52 **Targeted case management gap funding.**

Amends § 256B.076 by adding subd. 8. Paragraph (a) defines “unacceptable loss.”

Paragraph (b) requires the commissioner to pay targeted case management gap funding to a county for calendar years in which the county experiences an unacceptable loss.

Paragraph (c) outlines requirements for gap funding base calendar years, timelines, and adjustments.

Paragraph (d) requires the commissioner to pay targeted case management gap funding to a county within 90 days of completing reconciliation, in an amount equaling the difference between the finalized amount of targeted case management federal reimbursement after reconciliation for that calendar year and 90 percent of the average federal reimbursement received by that county during the base calendar years, including any adjustments.

Paragraph (e) specifies that targeted case management gap funding is a forecasted program.

53 **Payment for targeted case management.**

Amends § 256B.0924, subd. 6, as amended by Laws 2026, ch. 88, art. 1, § 126, and Laws 2026, ch. 95, art. 4, § 21. Makes conforming changes.

Section	Description - Article 3: Health Care
54	**Eligible services.** Amends § 256B.094, subd. 2. Makes clarifying changes; adds "economic support" to case management services.
55	**Coordination and provision of services.** Amends § 256B.094, subd. 3. Changes terminology from "prepaid medical assistance provider" to "managed care organization (MCO) or county-based purchasing (CBP) plan." Includes medical services in addition to mental health services. Carves out child welfare case management services from Minnesota health care programs managed care contracts. Makes conforming changes.
56	**Medical assistance reimbursement of case management services.** Amends § 256B.094, subd. 6. Makes technical and conforming changes related to payment rates for case management services under medical assistance.
57	**Agency duties.** Amends § 256B.0949, subd. 16, as amended by Laws 2026, ch. 95, art. 4, § 24. Updates cross-references related to the recodification of section 256B.04, subdivision 21.
58	**Provider shortage; authority for exceptions.** Amends § 256B.0949, subd. 17. Updates a cross-reference related to the recodification of section 256B.04, subdivision 21.
59	**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.
60	**Data sharing for program integrity.** Adds a subdivision to § 256B.69. Directs the commissioner of human services to share summary data from a written report concerning fraud received from a managed care plan contracted under MA with other managed care plans contracted under MA.

Section	Description - Article 3: Health Care
61	**Networks.** Amends § 256B.69, subd. 37. Provides that a managed care organization contracted under MA or MinnesotaCare is not required to include any providers in its network before approving the provider's credentials in accordance with the credentialing process that is set out in state statutes. Makes this section effective January 1, 2027.
62	**Effective date.** Amends Laws 2026, First Special Session ch. 3, art. 8, § 43. Modifies an effective date related to implementation of the single NEMT administrator for MA. Provides that the effective date is upon implementation of the administrator rather than a specified date. Makes the section effective immediately.
63	**Mandatory compliance training for currently enrolled high-risk medical assistance providers.** Requires owners and employees of any medical assistance provider agency subject to mandatory compliance training and enrolled before January 1, 2027, to complete initial compliance training by January 1, 2028.
64	**Repealer.** Repeals section 256B.0701, subd. 11 (Recuperative care; requirements for provider enrollment; compliance training).

Article 4: 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, and clarifies and modifies fraud investigation procedures and pre- and post-payment review authority in MA. The article also modifies licensing and change in ownership provisions, 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 - Article 4: Department of Human Services Office of Inspector General Policy
1	**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.
2	**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.
3	**Individual who is related.** Amends § 245A.02, subd. 13. Specifies that an individual who is related includes any individual who has a listed relationship through marriage. Provides a July 1, 2026, effective date.
4	**Exclusion from licensure.** Amends § 245A.03, subd. 2. Allows programs initially licensed before July 1, 2026, to continue operating under the previous definition of "related individual" until the service recipient related to the license holder is no longer receiving services. Makes this section effective July 1, 2026.
5	**Change in ownership.** Amends § 245A.043, subd. 2. Removes exception to the requirement to submit a new licensing application upon a change in ownership. The exception provided that no change in ownership occurred if at least one controlling individual was affiliated as a controlling individual for the license for at least the previous 12 months immediately preceding the change. Makes technical conforming changes. Makes this section effective October 1, 2026.
6	**Review of change in ownership.** Amends § 245A.043, subd. 2a. Makes conforming changes related to the removal of the exception in section 5. Makes this section effective October 1, 2026.

Section	Description - Article 4: Department of Human Services Office of Inspector General Policy
7	**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.
8	**License suspension, revocation, or fine.** Amends § 245A.07, subd. 3. Updates cross-reference.
9	**License or certification fee for certain programs.** Amends § 245A.10, subd. 4. Makes technical changes.
10	**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.
11	**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.
12	**Serious maltreatment.** 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.
13	**Programs licensed by the commissioner.** Amends § 245C.03, subd. 1. Adds children's foster residence settings to list of licensed programs for which background studies must be conducted. Provides a November 3, 2026, effective date.

Section	Description - Article 4: Department of Human Services Office of Inspector General Policy
14	**Licensed programs; other child care programs.** 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.
15	**Study subject affiliated with multiple facilities.** Amends § 245C.07. Removes language allowing child foster care background studies to be transferable across all licensed programs. Provides a July 1, 2026, effective date.
16	**Activities pending completion of a background study.** 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. Provides a July 1, 2026, effective date.
17	**15-year disqualification.** 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.
18	**Ten-year disqualification.** 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.
19	**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.
20	**Licensed family foster setting disqualifications.** Amends § 245C.15, subd. 4a. Updates cross-references.

Section	Description - Article 4: Department of Human Services Office of Inspector General Policy
21	**Scope of set-aside.** Amends § 245C.22, subd. 5. Updates cross-reference.
22	**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.
23	**Protection-related rights.** Amends § 245D.04, subd. 3. Clarifies that certain 245D resident rights cannot be restricted. Provides an immediate effective date.
24	**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.
25	**Fraud.** Amends § 256B.02 by adding subd. 20. Defines "fraud" under chapter 256B.
26	**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.
27	**Requirements for provider enrollment of personal care assistance provider agencies.** Amends § 256B.0659, subd. 21. Requires surety bonds for personal care assistance provider agencies to be purchased new annually, rather than renewed.
28	**Provider qualifications and duties.** Amends § 256B.0701, subd. 9. Requires surety bonds for recuperative care services provider agencies to be purchased new annually, rather than renewed.

Section	Description - Article 4: Department of Human Services Office of Inspector General Policy
29	**Access to medical records.** 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.
30	**Requirements for enrollment of CFSS agency-providers.** 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.
31	**Consultation services provider qualifications and requirements.** 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.
32	**Facility.** Amends § 260E.04, subd. 6. Adds psychiatric residential treatment facilities (PRTFs) to definition of "facility" in the Maltreatment of Minors Act.
33	**Reports of maltreatment in a facility.** Amends § 260E.11, subd. 1. Specifies that maltreatment in a PRTF must be reported to the Department of Health (MDH).
34	**Facilities and schools.** Amends § 260E.14, subd. 1. Specifies that MDH is the agency responsible for screening and investigating allegations of maltreatment in PRTFs.
35	**Lead investigative agency.** Amends § 626.5572, subd. 13. Modifies the definition of "lead investigative agency" for the Vulnerable Adults Act to add PRTFs.
36	**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.

Section	Description - Article 4: Department of Human Services Office of Inspector General Policy
37	**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). Makes paragraph (a) effective October 1, 2026.

Article 5: 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.

Section	Description - Article 5: Background Studies
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 family 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 MA. 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.

Section	Description - Article 5: Background Studies
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. Requires the commissioner to conduct background studies on any individual with an ownership stake of at least five percent, or operator of a peer recovery support services provider. 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.
7	**Fingerprints and photograph.** Amends § 245C.05, subd. 5. Adds family 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,

Section	Description - Article 5: Background Studies
	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 6: Behavioral Health

This article allows the commissioner of human services to distribute money for mental health services through direct payments to counties and Tribes under certain circumstances, and 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 billing limits for certain behavioral health services, and establishes MA coverage for detained individuals and an MA benefit for carceral targeted case management services.

Section	Description - Article 6: Behavioral Health
1	**Direct payment.** Amends § 245.4661 by adding subd. 1a. Defines “direct payment” for purposes of adult mental health initiative services, to means a funding mechanism used by the commissioner to distribute state appropriations to a county or Tribe for the purpose of carrying out authorized duties, services, or activities. Specifies that a direct payment is not a grant.
2	**Authority and rulemaking.** Amends § 245.4661 by adding subd. 3a. Allows the commissioner to distribute money through direct payments to counties or Tribes when the commissioner determines that a direct payment is the most effective and efficient method to support the delivery of adult mental health services, Tribal government activities, or county responsibilities related to adult mental health. Requires the commissioner to establish eligibility criteria, allowable uses, documentation standards, and reporting requirements for recipients of direct payments. Permits the commissioner to engage in rulemaking for these purposes.

Section	Description - Article 6: Behavioral Health
	Requires the commissioner to submit a report to the legislature on direct payments by January 1, 2027.
3	**Programs and eligible services.** Amends § 245.4661, subd. 9. Modifies language to reflect the allowance of direct payments. Provides an immediate effective date.
4	**Commissioner duty to report on use of grant funds biennially.** Amends § 245.4661, subd. 10. Makes technical change. Provides an immediate effective date.
5	**Oversight of direct payments.** Amends § 245.4661 by adding subd. 12. Requires the commissioner to develop and maintain monitoring, financial review, and accountability procedures for all adult mental health initiative direct payments. Requires recipients of direct payments to comply with all documentation, reporting, and expenditure requirements; allows the commissioner to require corrective action, suspend payments, or recover money for noncompliance. Requires the commissioner to develop a direct payment acknowledgment process; permits rulemaking; and requires a report to the legislature by January 1, 2027, on the procedures developed under this section. Provides an immediate effective date.
6	**American Indian programs.** Amends § 254A.03, subd. 2. Makes conforming change related to direct payments. Makes the section effective January 1, 2027.
7	**Tribal allocation.** Amends § 254B.02, subd. 5. Makes conforming change related to direct payments. Makes the section effective January 1, 2027.
8	**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 6: Behavioral Health
9	**Billing limits.** Amends § 254B.0505 by adding subd. 9. Establishes a five hour per week billing limit for treatment coordination services. Makes the section effective January 1, 2027.
10	**Annual adjustments.** Amends § 254B.0509, subd. 2. Updates cross-reference; clarifies that reimbursement rates must not be adjusted lower than those established on January 1, 2026. Provides an immediate effective date.
11	**Withdrawal management start-up and capacity-building grants.** Amends § 254B.17. Expands grantees and eligible uses of withdrawal management start-up and capacity-building grants.
12	**Medical assistance costs for certain inmates.** Amends § 256B.04, subd. 23. Requires the commissioner of human services to execute an interagency agreement with the commissioner of corrections to recover the state cost attributable to MA eligibility for inmates of public institutions admitted to a medical institution on an inpatient basis. Provides an immediate effective date.
13	**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.
14	**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.

Section	Description - Article 6: Behavioral Health
15	**Billing limits.** Amends § 256B.0623 by adding subd. 15. Effective January 1, 2027, limits billing for adult rehabilitative mental health services to four hours per week and 18 hours per month. Requires prior authorization for services exceeding 200 hours per year.
16	**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.
17	**Billing limits.** Amends § 256B.0671 by adding subd. 14. Limits billing for child and family psychoeducation services to two hours per day, three days per week per recipient. Makes this section effective January 1, 2027.
18	**Eligible individuals.** Amends § 256B.0761, subd. 2. Makes conforming change.
19	**Eligible correctional facilities.** Amends § 256B.0761, subd. 3. Removes two facilities for delinquent children and youth from the list of facilities eligible for the reentry demonstration waiver.
20	**Billing limits.** Amends § 256B.0943 by adding subd. 15. Limits billing for children's therapeutic services and supports skills training and mental health behavioral aide services. Makes this section effective January 1, 2027.
21	**License required; staffing qualifications.** Amends § 256I.04, subd. 2a. Moves forward effective date for changes made to housing supports for recovery residences from January 1, 2027, to July 1, 2026.
22	**Collection; disposition.** Amends § 297E.02, subd. 3. Specifies that the balance of amounts appropriated from the general fund for the compulsive gambling program that are unencumbered and unspent at the close of a fiscal year must be available in the next fiscal year for the same purposes and must not cancel. Requires the annual reconciliation to include any rollover amounts from the previous fiscal year and the utilization of those amounts during the current reporting period.

Section	Description - Article 6: Behavioral Health
23-33	**Effective dates.** Moves forward effective dates for changes made to recovery residence provisions, and establishing certification, from January 1, 2027, to July 1, 2026.
34	**Billing limits.** Amends Laws 2026, ch. 95, art. 5, § 23, subd. 7. Modifies peer recovery support services billing limits by clarifying that no more than two hours per day per recipient may be provided by telehealth, and providing an annual limit of 520 hours per recipient. Makes this section effective January 1, 2027.
35	**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. Makes this section effective January 1, 2027, or upon federal approval, whichever is later.
36	**Direct payment.** Amends § 245.4661 by adding subd. 1a. Defines “direct payment” for purposes of adult mental health initiative services, to means a funding mechanism used by the commissioner to distribute state appropriations to a county or Tribe for the purpose of carrying out authorized duties, services, or activities. Specifies that a direct payment is not a grant.

Article 7: 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, and makes changes related to intensive residential treatment services (IRTS).

Section	Description - Article 7: Uniform Service Standards
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.
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.
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.
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.

Section	Description - Article 7: Uniform Service Standards
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	**License requirements.** Amends § 245G.03, subd. 1. Updates cross-references.
11	**Certification required.** Amends § 245I.011, subd. 3. Updates cross-reference; removes language relating to certification of CCBHCs.
12	**Programs certified under chapter 256B.** Amends § 245I.011, subd. 5. Strikes certification language for newly licensed services.
13	**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.
14	**Alcohol and drug counselor.** Amends § 245I.02 by adding subd. 1a. Adds definition of “alcohol and drug counselor” to chapter 245I.
15	**Comprehensive evaluation.** Amends § 245I.02 by adding subd. 10a. Adds definition of “comprehensive evaluation” to chapter 245I.
16	**Initial evaluation.** Amends § 245.02 by adding subd. 18a. Adds definition of “initial evaluation” to chapter 245I.
17	**Psychotherapy.** Amends § 245I.02 by adding subd. 31a. Adds definition of “psychotherapy” to chapter 245I.
18	**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.

Section	Description - Article 7: Uniform Service Standards
19	**Treatment plan.** Amends § 245I.02, subd. 39. Modifies definition to specify that for CCBHC services, a treatment plan is the integrated treatment plan.
20	**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.
21	**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.
22	**Behavioral health practitioner scope of practice.** Amends § 245I.04, subd. 5. Adds crisis planning to the scope of practice for behavioral health practitioners.
23	**Mental health behavioral aide scope of practice.** Amends § 245I.04, subd. 17. Modifies mental health behavioral aide scope of practice to only allow them to provide skill-building services to a child client.
24	**Generally.** Amends § 245I.06, subd. 1. Adds modeling respectful and inclusive service practices to treatment supervision requirements.
25	**Treatment supervision planning.** Amends § 245I.06, subd. 2. Adds approval by the staff person to treatment supervision plan requirements; makes technical change.
26	**Treatment supervision and direct observation of mental health rehabilitation workers and mental health behavioral aides.** Amends § 245I.06, subd. 3. Updates terminology and adds a citation.
27	**Personnel files.** Amends § 245I.07. Adds paragraph (c), requiring CCBHC personnel files for staff who provide substance use disorder (SUD) treatment services to include records of required training.

Section	Description - Article 7: Uniform Service Standards
28	**Evaluation, treatment authorization, and planning in a certified community behavioral health clinic.** Amends § 245I.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 § 245I.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 § 245I.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.
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	**Required intensive residential treatment services.** Amends § 245I.23, subd. 4. Clarifies that IRTS providers must have the capacity to provide daily rehabilitative mental health services to clients.

Section	Description - Article 7: Uniform Service Standards
34	**Required residential crisis stabilization services.** Amends § 245I.23, subd. 5. Clarifies that residential crisis stabilization services providers must have the capacity to provide daily crisis stabilization services to clients.
35	**Intensive residential treatment services assessment and treatment planning.** Amends § 245I.23, subd. 7. For an IRTS initial treatment plan, adds a requirement to specify the frequency of identified interventions. Adds requirements for IRTS individual treatment plans and updates to individual treatment plans.
36	**Minimum treatment team staffing levels and ratios.** Amends § 245I.23, subd. 10. Requires an IRTS license holder to maintain documentation of a daily staffing schedule that indicates the names and credentials of individuals providing services, in compliance with DHS record retention requirements.
37	**Daily documentation.** Amends § 245I.23, subd. 12. For a client's daily summary, adds requirement for documentation of any daily medically necessary rehabilitation service.
38	**Admissions referrals and determinations.** Amends § 245I.23, subd. 17. Requires an IRTS license holder to document client eligibility.
39	**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.
40	**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.

Section	Description - Article 7: Uniform Service Standards
41	**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.
42	**Scope.** Amends § 256B.0623, subd. 1. Adds cross-reference to new licensure statute for ARMHS.
43	**Eligibility.** Amends § 256B.0623, subd. 1. Adds cross-reference to standard diagnostic assessment statute.
44	**Additional requirements.** Amends § 256B.0623, subd. 1. Removes language from ARMHS MA statute that is moved to new licensing statute under chapter 245I.
45	**Scope.** Amends § 256B.0624, subd. 1. Adds cross-reference to new licensure statute for mobile crisis response services.
46	**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.
47	**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.
48	**Certified community behavioral health clinic services.** Amends § 256B.0625, subd. 5m, as amended by Laws 2026, ch. 95, art. 5, § 27. Adds cross-references to CCBHC licensure statute; makes technical changes.
49	**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 paragraph (c), requiring providers to document the use of psychotherapy as part of a

Section	Description - Article 7: Uniform Service Standards
	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.
50	**Determination of client eligibility.** Amends § 256B.0943, subd. 3. Makes conforming changes.
51	**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.
52	**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.
53	**Lead investigative agency.** Amends § 626.5572, subd. 13, as amended by Laws 2026, ch. 95, art. 7, § 25. 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.
54	**Revisor instruction.** Instructs the revisor to renumber listed statutes.
55	**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). 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).

Section	Description - Article 7: Uniform Service Standards
56	**Effective date.** Makes this article effective January 1, 2028.

Article 8: Uniform Service Standards Conforming Changes

This article makes technical and conforming changes throughout statutes, made necessary by changes in the Uniform Service Standards article.

Article 9: Aging and Disability Services

This article contains provisions related to providing for MnCHOICES efficiencies, prohibiting colocation of certain home and community-based residential services, sunsetting the long-term services and supports loan program, requiring interpretive guidelines for disability waiver regulation, modifying shared services provided under the personal care assistance (PCA) and community first services and supports (CFSS) programs, establishing billing limits for various home and community-based services, modifying the Disability Waiver Rate System, requiring additional documentation for residential support services providers, establishing a nursing facility workforce wage supplement program, adding a new adult foster care moratorium exception, establishing a waiver case management advisory working group, establishing a MnCHOICES redesign working group, reforming environmental accessibility adaptations for homes and vehicles, and requiring the commissioner to conduct studies and evaluations on various services and programs.

Section	Description - Article 9: Aging and Disability Services
1	**Nursing facility level of care.** Amends § 144.0724, subd. 11. Makes conforming changes related to MnCHOICES efficiencies. Provides a January 1, 2027, effective date.
2	**Notification of affected municipality.** Amends § 245A.04, subd. 2. Removes exemption to notification requirements for programs considered a permitted single-family residential use. Specifies what the written notification must include. Provides a July 1, 2026, effective date.

Section	Description - Article 9: Aging and Disability Services
3	**Meeting fire and safety codes.** Amends § 245A.04, subd. 2a. Allows the commissioner of human services to delegate authority to a county agency or local unit of government, at the request of the county agency or local unit of government, to inspect a residential program serving six or fewer persons for compliance with applicable physical plant licensing requirements and zoning ordinances. Prohibits the county agency or local unit of government conducting inspections under delegated authority from assessing any additional fees for conducting an inspection under delegated authority. Requires the inspecting county agency or local unit of government to notify the commissioner of violations or concerns within ten working days. Requires the commissioner to ensure that requirements are uniformly enforced throughout the state by reviewing inspecting county agencies or local units of government for compliance at least every four years. Provides a January 1, 2027, effective date.
4	**Colocation of certain home and community-based residential settings.** Amends § 245A.042, by adding subd. 7. Prohibits the commissioner from authorizing services in or issuing an initial license for specified residential settings or programs unless the proposed setting meets the home and community-based standards under this subdivision. Prohibits newly licensed specified residential settings from being located on the same property or on an adjoining property of an existing specified residential setting. Defines “adjoining property” for purposes of this subdivision.
5	**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.
6	**Interagency agreements with Department of Health.** Amends § 256.01, subd. 21. Makes a conforming change related to the limitation on colocation of certain home and community-based residential settings.
7	**Long-term services and supports loan program.** Amends § 256.4792, subd. 1. Prohibits the commissioner from issuing any new loans under the long-term services and supports loan program after June 30, 2026.

Section	Description - Article 9: Aging and Disability Services
8	**Loan repayment.** Amends § 256.4792, subd. 7. Requires the commissioner to report to the legislative committees with jurisdiction over nursing facilities, all nursing facilities that are delinquent in their long-term services and supports loan repayments. Makes this reporting requirement expire when there are no outstanding balances from loan awards issued under the long-term services and supports loan program.
9	**Loan program expiration.** Amends § 256.4792, by adding subd. 11. Makes the long-term services and supports loan program expire after the commissioner collects all loan repayments incurred on or before June 30, 2026. Requires the commissioner to notify the revisor of statutes once all loan repayments are collected.
10	**Exemptions and emergency admissions.** Amends § 256.975, subd. 7b. Makes conforming changes related to MnCHOICES efficiencies. Provides a January 1, 2027, effective date.
11	**Interpretive guidelines for disability waiver regulation.** Amends § 256B.04, by adding subd. 28. Requires the commissioner to develop and publish interpretive guidelines within 120 days of the effective date of any statutory changes, waiver plan amendments, state or federal administrative rulings, or state or federal court decisions that affect policies or reimbursement for disability waiver services. Provides a July 1, 2028, effective date.
12	**Certified assessor team.** Amends § 256B.04, by adding subd. 29. Requires the commissioner to employ certified assessors within the department to conduct MnCHOICES assessments on behalf of lead agencies under conditions determined by the commissioner. Prohibits the certified assessors employed by the commissioner from performing any lead agency responsibilities under MnCHOICES other than assessments. Provides a July 1, 2027, effective date.
13	**Documentation of personal care assistance services provided.** Amends § 256B.0659, subd. 12. Corrects terminology.

Section	Description - Article 9: Aging and Disability Services
14	**Shared services.** Amends § 256B.06659, subd. 16. Clarifies shared services provided under the PCA program.
15	**Shared services; rates.** Amends § 256B.0659, subd. 17. Defines "additional revenue for shared services" and "wages and wage-related costs" under the subdivision of statute governing shared services provided under the PCA program. Makes technical and clarifying changes. Requires PCA provider agencies to use 90 percent of the additional revenue for shared services for wages and wage-related costs of the personal care assistant providing the shared services. Lists items for which a PCA provider agency is prohibited from using the additional revenue for shared services.
16	**PCA choice option; qualifications; duties.** Amends § 256B.0659, subd. 19. Corrects terminology.
17	**Assessment and support planning; supplemental information.** Amends § 256B.0911, subd. 30. Removes language related to verbal attestation to no changes in needs or services. The federal Centers for Medicare and Medicaid Services denied Minnesota's request to allow verbal attestation.
18	**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.
19	**Billing limits.** Amends § 256B.0922, by adding subd. 3. Effective January 1, 2027, or upon federal approval, whichever is later, establishes billing limits for certain services provided under the essential community supports program. Provides an immediate effective date.
20	**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.

Section	Description - Article 9: Aging and Disability Services
	Provides an immediate effective date.
21	**Billing limits.** Amends § 256B.4912, by adding subd. 17. Effective January 1, 2027, or upon federal approval, whichever is later, establishes billing limits for certain services provided under the brain injury, community alternative care, community access for disability inclusion, and developmental disabilities waivers. Provides an immediate effective date.
22	**Prohibition on room and board payments.** Amends § 256B.4912, by adding subd. 18. Prohibits providers from using MA money to pay for room and board. Prohibits home and community-based services providers from paying for certain items or taking certain actions using MA payments or revenue. Provides a January 1, 2027, effective date.
23	**Applicable services.** Amends § 256B.4914, subd. 3. Effective October 1, 2027, or upon federal approval, whichever is later, adds integrated community supports access services to the list of services reimbursed under the Disability Waiver Rate System (DWRS).
24	**Base wage index; calculations.** Amends § 256B.4914, subd. 5a. Effective October 1, 2027, or upon federal approval, whichever is later, adds DWRS base wage calculations for integrated community supports staff.
25	**Residential support services; generally.** Amends § 256B.4914, subd. 6. Effective October 1, 2027, or upon federal approval, whichever is later, modifies the list of services included under residential support services under DWRS by removing integrated community supports and adding integrated community supports access services.
26	**Community residential services; component values and calculation of payment rates.** Amends § 256B.4914, subd. 6a. Effective July 1, 2027, or upon federal approval, whichever is later, establishes billing limits for community residential services. Requires the commissioner to provide an exception process to the billing limits for individuals with extraordinary needs who might end up in institutional settings without additional authorized individual hour inputs.

Section	Description - Article 9: Aging and Disability Services
	Provides an immediate effective date.
27	**Integrated community supports; component values and calculation of payment rates.** Amends § 256B.4914, subd. 6c. Requires the commissioner to establish maximum allowable in-person and remote service hours used in the rate methodology for integrated community supports based on the recipient's case mix classification. Effective January 1, 2027, establishes hourly limits under DWRS based on case mix classification. Specifies this subdivision expires upon the effective date of DWRS payment rates for integrated community supports access services and integrated community supports unit-based services with programming, which is October 1, 2027.
28	**Payment for customized living.** Amends § 256B.4914, subd. 6d. Effective January 1, 2027, or upon federal approval, whichever is later, sets customized living monthly service rate limits equal to the customized living monthly service rate limits determined under the elderly waiver multiplied by 126.36 percent. Provides an immediate effective date.
29	**Integrated community supports access services; component values and calculation of payment rates.** Amends § 256B.4914, by adding subd. 6e. Sets component values and the payment rate calculation for integrated community supports access services under DWRS. Makes this section effective October 1, 2027, or upon federal approval, whichever is later.
30	**Day support services; component values and calculation of payment rates.** Amends § 256B.4914, subd. 7b. Effective January 1, 2027, or upon federal approval, whichever is later, sets the billing limit for day support services equal to a maximum of eight hours per day per recipient. Provides an immediate effective date.
31	**Unit-based services with programming; component values and calculation of payment rates.** Amends § 256B.4914, subd. 8. Effective January 1, 2027, or upon federal approval, whichever is later, modifies billing limits under DWRS for individualized home supports with training and individualized home supports with family training.

Section	Description - Article 9: Aging and Disability Services
	Provides an immediate effective date.
32	**Integrated community supports unit-based services with programming; component values and calculation of payment rates.** Amends § 256B.4914, by adding subd. 8a. Sets component values, the payment rate calculation, and maximum allowable in-person and remote service hours for integrated community supports unit-based services with programming under DWRS. Makes this section effective October 1, 2027, or upon federal approval, whichever is later.
33	**Unit-based services without programming; component values and calculation of payment rates.** Amends § 256B.4914, subd. 9. Effective January 1, 2027, or upon federal approval, whichever is later, sets the billing limit for awake night supervision and asleep night supervision under DWRS. Provides an immediate effective date.
34	**Respite services; component values and calculation of payment rates.** Amends § 256B.4914, subd. 9a. Effective January 1, 2027, or upon federal approval, whichever is later, sets the billing limit for in-home respite services under DWRS equal to a maximum of 30 consecutive days per respite occurrence. Provides an immediate effective date.
35	**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 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.

Section	Description - Article 9: Aging and Disability Services
36	**Transportation.** Amends § 256B.4914, subd. 13. Effective January 1, 2027, or upon federal approval, whichever is later, sets the billing limit for waiver transportation under DWRS equal to a maximum of 28 one-way trips per week per participant. Provides an immediate effective date.
37	**Integrated community supports access services; service standards and billing criteria.** Amends § 256B.4914, by adding subd. 21. Defines "integrated community supports access services" under the section of statutes governing DWRS. Establishes service standards and billing criteria for integrated community supports access services, which is a new service provided under the MA disability waivers. Makes this section effective October 1, 2027, or upon federal approval, whichever is later.
38	**Administrative fees charged by providers and vendors.** Amends § 256B.4914, by adding subd. 22. Effective July 1, 2027, or upon federal approval, whichever is later, requires the commissioner to limit administrative fees charged by enrolled providers and vendors approved by lead agencies to no more than six percent of the total cost of the service or purchased goods. Lists the services under DWRS to which the administrative fee limit applies. Provides an immediate effective date.
39	**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.
40	**Community first services and supports; covered services.** Amends § 256B.85, subd. 7. Adds shared services to the list of services covered under CFSS.

Section	Description - Article 9: Aging and Disability Services
41	**Shared services under the agency-provider model.** Amends § 256B.85, by adding subd. 7c. Requires the commissioner to authorize shared services arrangements if the commissioner determines that a shared services arrangement is appropriate to meet all the participants' needs and sufficient to maintain the participants' health and safety. Prohibits the commissioner from reducing the total number of authorized units for a participant who elects to receive shared services. Requires an agency-provider to offer a participant options related to shared services, one-on-one services, or a combination of both types of services. Specifies shared services may be elected at the sole discretion of either the participant or the participant's representative and allows the participant or the participant's representative to withdraw from participating in a shared services arrangement at any time.
42	**Shared services rates under the agency-provider model.** Amends § 256B.85, by adding subd. 7d. Sets the maximum rates for shared services under CFSS.
43	**Pass-through for shared services under the agency-provider model.** Amends § 256B.85, by adding subd. 7e. Requires 90 percent of the additional revenue for shared services under CFSS to be used for wages and wage-related costs of the support worker providing the shared services.
44	**Shared services under the budget model.** Amends § 256B.85, by adding subd. 7f. Requires the commissioner to authorize shared services arrangements if the commissioner determines that a shared services arrangement is appropriate to meet all the participants' needs and sufficient to maintain the participants' health and safety. Prohibits the commissioner from reducing the total number of authorized units for a participant who elects to receive shared services. Requires the participants or participants' representatives who elect to share services under the budget model to jointly develop a shared services agreement and allows the participant or the participant's representative to withdraw from participating in a shared services arrangement at any time. Requires the commissioner to develop and publish recommendations for negotiating wages for support workers providing shared services under the budget model.
45	**Pass-through for shared services under the budget model.** Amends § 256B.85, by adding subd. 7g. Requires participant employers to pay the individual support worker providing shared services under the budget model a specified percentage of the minimum wage specified in the direct support services collective bargaining agreement in effect at the time the services are provided.

Section	Description - Article 9: Aging and Disability Services

46 **Community first services and supports; definitions.**

Creates § 256B.8502.

Subd. 1. Scope. Specifies the terms defined in this section apply to the sections of statute related to CFSS and CFSS payment rates.

Subd. 2. Additional revenue for shared services. Defines "additional revenue for shared services."

Subd. 3. Individual provider support worker. Defines "individual provider support worker."

Subd. 4. Wages and wage-related costs. Defines "wages and wage-related costs."

47 **Nursing facility workforce wage supplement program.**

Creates § 256R.60.

Subd. 1. Program established. Establishes a program to provide supplemental wage payments to nursing home employees.

Subd. 2. Definitions. Defines the terms "commissioner," "covered employee," and "covered employer" for purposes of the nursing facility workforce wage supplement program.

Subd. 3. Eligibility for supplemental wage payments. Specifies covered employees who meet certain criteria are eligible to receive a onetime payment of up to $400.

Subd. 4. Employee and wage reporting by covered employers. Requires covered employers to provide the commissioner with wage and hour data for the January 1, 2026, to June 30, 2026, period for each covered employee by July 31, 2026. Allows the commissioner to request additional data from covered employers. Specifies that a covered employer that fails to comply with employee and wage reporting requirements may be subject to a payment reduction.

Subd. 5. Application and payment processes. Lays out commissioner's duties related to establishing an application and payment process for the nursing facility workforce wage supplement program. Allows the commissioner to contract with a third party to implement part or all of the application and payment processes. Specifies the commissioner's determination of eligibility for payments and amounts is final and not subject to appeal. Requires covered employers to provide notice to current employees of the nursing facility workforce wage

Section	Description - Article 9: Aging and Disability Services

supplement program using the same means the covered employer uses to provide other work-related notices to employees.

Subd. 6. Audits and recoupment. Allows the commissioner to perform an audit up to six years after a payment is awarded and requires the commissioner to attempt to recoup payments the commissioner determines were not in compliance with the nursing facility workforce wage supplement program.

Subd. 7. Payments not to be considered income. Prohibits payments under the nursing facility workforce wage supplement program from being considered income, assets, or personal property for purposes of determining or recertifying eligibility for a variety of income assistance programs and Medicaid.

Subd. 8. Expiration. Provides a June 30, 2028, expiration date.

Provides an immediate effective date.

48 **Billing limits.**

Amends § 256S.15, by adding subd. 3. Effective January 1, 2027, or upon federal approval, whichever is later, establishes billable unit maximums for certain services authorized under alternative care and the elderly waiver programs.

Provides an immediate effective date.

49 **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 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.

Section	Description - Article 9: Aging and Disability Services

50 **Administrative fees charged by providers or vendors.**

Amends § 256S.21, subd. 5. Effective July 1, 2027, or upon federal approval, whichever is later, requires the commissioner to limit administrative fees charged by enrolled providers and vendors approved by lead agencies to no more than six percent of the total cost of the service or purchased goods. Lists the services under the elderly waiver to which the administrative fee limit applies.

Provides an immediate effective date.

51 **Waiver reimagine phase II.**

Amends Laws 2021, First Special Session ch. 7, art. 13, § 73, as amended by Laws 2025, First Special Session ch. 9, art. 2, § 56. Requires information related to the total disability waiver budget available to a person, the services for which the person is eligible, and the services the person has chosen and used to be provided to persons currently using disability waiver services at least 12 months prior to the date their services will be subject to the budget. Requires the commissioner to: (1) establish a phased approach to implementing the two-waiver program structure; and (2) consult with the Olmstead Implementation Office prior to seeking federal approval to ensure the phased approach promotes community integration and continuity of care.

Provides an immediate effective date.

52 **Licensing moratorium exceptions.**

Amends Laws 2026, ch. 95, art. 4, § 2. Adds an exception to the adult foster care moratorium for new foster care licenses or community residential setting licenses for people receiving customized living or 24-hour customized living services under the brain injury or community access for disability inclusion waiver plans and residing in the customized living setting before July 1, 2026. Makes the exception available under certain conditions and until June 30, 2027.

53 **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.

Section	Description - Article 9: Aging and Disability Services

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.

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.

54 **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 (HCBS) 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.

55 **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.

Section	Description - Article 9: Aging and Disability Services

Subd. 2. Community consultation. Requires the commissioner to consult with the community in conducting the review of ICS services and lists the community members 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 January 1, 2028.

56 **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.

57 **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.

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

Section	Description - Article 9: Aging and Disability Services

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.

58 **Direction to commissioner; environmental accessibility adaptations for homes.**

By October 1, 2026, requires the commissioner of human services to submit to the Centers for Medicare and Medicaid Services waiver plan amendments for the MA disability waivers to implement specified reforms to environmental accessibility adaptations for homes, including separating the treatment of home modifications from the treatment of vehicle modifications and establishing caps on the number, size, and cost of common home modifications.

59 **Direction to commissioner; environmental adaptations for vehicles.**

By October 1, 2026, requires the commissioner of human services to submit to the Centers for Medicare and Medicaid Services waiver plan amendments for the MA disability waivers to implement specified reforms to environmental accessibility adaptations for vehicles, including separating the treatment of vehicle modifications from the treatment of home modifications and replacing the existing $40,000 annual limit for vehicle modifications with a $40,000 five-year limit.

60 **Direction to commissioner; home and community-based services access rule implementation.**

Requires the commissioner of human services to develop systems and capacity to comply with the requirements of the federal access rule to improve access to care, quality and health outcomes, and program integrity in MA home and community-based services. Specifies the activities the initial phase of implementation efforts must include.

Provides an immediate effective date.

61 **Revisor instruction.**

Instructs the revisor of statutes to renumber definitions in the statutory language governing CFSS and CFSS payment rates, rearranging the renumbered and existing definitions as necessary to place them in alphabetical order, and to revise all statutory cross-references consistent with this recoding.

Section	Description - Article 9: Aging and Disability Services
62	**Repealer.** Repeals Minn. Stat. § 256B.0911, subd. 21 (MnCHOICES assessments; exceptions following institutional stay), effective January 1, 2027; Minn. Stat. 256B.0911, subds. 24a (verbal attestation or alternative to replace required reassessment signatures) and 25a (attesting to no changes in needs or services), effective immediately; and 256B.0921 (HCBS innovation pool).

Article 10: Electronic Visit Verification

This article provides for an expansion of electronic visit verification under MA.

Section	Description - Article 10: Electronic Visit Verification
1	**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.
2	**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.
3	**Documentation; establishment and operation.** Amends § 256B.073, subd. 1. Makes technical changes.
4	**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

Section	Description - Article 10: Electronic Visit Verification

- Home health agency
- Individual
- Managed care organization
- Manual visit
- Provider
- State-provided electronic visit verification system
- Third-party electronic visit verification system
- Verification method
- Visit
- Worker

5 **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 system functions subject to electronic visit verification, including verification methods or technical requirements; and (2) waive electronic visit verification requirements for any service component or setting under specified conditions.

6 **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's 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.

7 **Provider responsibilities.**

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

8 **Vendor requirements.**

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

Section	Description - Article 10: Electronic Visit Verification
9	**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. 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 upon request.
10	**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 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. Provides an immediate effective date.
11	**Electronic visit verification and medical assistance claims validation.** Requires the commissioner to: (1) develop, test, and implement systems changes necessary to integrate data collected through electronic visit verification systems with Minnesota's Medicaid Management Information System; and (2) require managed care plans and county-based purchasing plans to ensure electronic visit verification and claims system interoperability by January 1, 2027. Requires data collected through electronic visit verification to be used as part of claims validation processes for services subject to electronic visit verification. Provides an immediate effective date.
12	**Repealer.** Repeals Minn. Stat. § 256B.073, subd. 4 (electronic visit verification; provider requirements). Provides a July 1, 2026, effective date.

Article 11: Miscellaneous

This article contains miscellaneous provisions related to child care provider compliance training; an assessment of state, county, and Tribal administrative roles in administering human services programs; an assessment of transferring the administration of medical assistance eligibility determinations from counties to the state; an evaluation of DHS structure and processes; and codifying the DHS Office of Inspector General.

Section	Description - Article 11: Miscellaneous
1	**Training required for payments.** Amends § 142E.16, by adding subd. 1a. Requires child care assistance providers receiving child care assistance program payments to complete compliance training developed by the commissioner that addresses program integrity requirements. Requires the commissioner to develop criteria, reporting requirements, and standards for when providers need to renew training after their initial registration. Specifies when providers must complete the initial training.
2	**Changes to grant programs.** Amends § 245.096. Modifies the reporting requirement threshold for DHS changes to mental health grant programs.
3	**Direction to commissioner; assessment of administration roles.** Requires the commissioners of human services and children, youth, and families, in consultation with Tribal Nations and counties, to conduct a study to assess and recommend improvements to roles and responsibilities of the state agencies, 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. Requires counties to provide information necessary to complete the study. By October 1, 2028, requires the commissioner to submit a report on the study to the legislature.
4	**Direction to commissioner; transfer assessment.** Requires the commissioner of human services to contract with a vendor to assess the administration of medical assistance and plan for a transfer of administration of medical assistance to the commissioner by January 1, 2033. Lists the items that must be included in the assessment and plan. Requires the commissioner to: (1) submit the assessment and plan to the legislature by October 1, 2028; and (2) consult with specified entities on the final deliverables included in the assessment.

Section	Description - Article 11: Miscellaneous
5	**Direction to commissioner of human services; evaluation of DHS structure and processes.** Requires the commissioner of human services to contract with an external consultant to make recommendations to improve the performance of DHS as the state's Medicaid agency. Specifies the items the consultant must evaluate. Requires the commissioner to submit reports, a summary of recommendations, and actions taken to the legislative committees with jurisdiction over health and human services policy and finance within 60 days of receiving the external consultant's recommendations.
6	**Direction to the commissioner of human services; codifying the Office of Inspector General.** By December 1, 2026, requires the commissioner of human services to provide statutory language that codifies the DHS Office of Inspector General to the legislative committees with jurisdiction over human services and the nonpartisan legislative staff whose drafting areas include human services. Specifies the information the statutory language must contain. Prohibits the commissioner from including desired policy changes to the office, its structure, or its duties within the codification language. Provides an immediate effective date.

Article 12: Department of Human Services Appropriations

This article contains adjustments to fiscal year 2026 and 2027 appropriations for the Department of Human Services for the central office, housing support, medical assistance, alternative care, the behavioral health fund, other long-term care grants, aging and adult services grants, disabilities grants, housing grants, adult mental health grants, child mental health grants, and substance use disorder grants; and provides for various transfers and cancellations.

Article 13: Other Agency Appropriations

This article contains adjustments to fiscal year 2027 appropriations for the Department of Health, the Department of Children, Youth, and Families, and the Department of Employment and Economic Development; and provides for certain cancellations.

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