SENATE
COUNSEL, RESEARCH, & FISCAL ANALYSIS

BILL SUMMARY

S.F. No. 4354 as amended by the A-2 – MEDICAL ASSISTANCE PROVIDER ENROLLMENT REQUIREMENTS MODIFICATIONS

Author: Senator Jim Abeler

Prepared by: Liam Monahan, Legislative Analyst (liam.monahan@mnsenate.gov)

Date: March 17, 2026

SF 4354, as amended by the A-2, contains two articles. Article 1 focuses primarily on modifications to the existing authority of the commissioner of human services to impose sanctions on medical assistance providers. Article 2 is focused primarily on modifications to medical assistance provider enrollment. Both articles include recodifications of the existing law with policy changes incorporated into the recodified language.

ARTICLE 1.

Article 1 is an amended version of SF 4354 as introduced. Large portions of this article are a recodification of **section 256B.064 - SANCTIONS; MONETARY RECOVERY**.

Section 1 clarifies that section 15.013, which is the generally applicable executive branch payment withhold and fraud language, does not apply to the commissioner of human services authority to impose sanctions under medical assistance.

Section 2 clarifies that section 245A.095, which the generally appliable Department of Human Services payment withhold and fraud language, does not apply to the commissioner of human service's authority to impose sanctions under medical assistance.

Section 3 clarifies the meaning of "abuse" for the purposes of the commissioner's authority to impose sanctions on medical assistance providers by clarifying that billing errors resulting in unintentional overcharges are not abuse and by classifying as abuse a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the individual or entity is legally entitled.

Section 4 makes technical and conforming changes related to the recodification and modernization of section 256B.064.

Section 5 makes technical and conforming changes related to the recodification and modernization of section 256B.064.

Section 6 makes technical and conforming changes related to the recodification and modernization of section 256B.064 and strikes language that is recreated as new subdivisions later in the bill.

Section 7 contains recodified language currently codified as section 256B.064, subdivision 2, paragraphs (g) and (h) that authorizes the commissioner to impose fines. This section contains no policy changes from existing law.

Section 8 contains recodified language currently codified as section 256B.064, subdivision 2, paragraph (e) that requires the commissioner to suspend or terminate a provider's participation in medical assistance when the provider is excluded from participation in Medicare. This section contains no policy changes from existing law.

Section 9 contains recodified and rewritten language currently codified as section 256B.064, subdivision 2, paragraph (a), second sentence that authorizes the commissioner under certain circumstances to withhold or reduce payments after notice but before a hearing. Paragraphs (b) and (c) modify the commissioner's authority by requiring the commissioner to ensure continuity of care for residents of nursing homes, convalescing care homes, 245D licensed residential supports and services, and 245D-licensed integrated community supports before imposing payment withholds or reductions on providers of these services.

Section 10 contains recodified and rewritten language currently codified as section 256B.064, subdivision 2, paragraphs (b) to (d) and (f), as well as a number of policy changes, related to the commissioner's obligation to withhold or reduce payments when the commissioner determines there are credible allegations of fraud against a provider.

Paragraph (a) contains the following changes to current law:

- increases the burden of proof for a credible allegation of fraud from "an indicium of reliability" to "a preponderance of the evidence;
- specifying that a credible allegation of abuse is not a credible allegation of fraud.

Paragraph (b) is new language limiting payment withholds and reductions to payment of submitted claims that are determined to be credibly fraudulent, unless the credible allegation if an allegation of pervasive fraud.

Paragraph (c) is new language providing a definition of "fraud".

Paragraph (d) is mostly existing language specifying examples of sources of allegations of fraud.

Paragraph (e) expands the current law list specifying what information must be included in a notice of withholding or reduction when the commissioner sends a notice.

Paragraph (f) is new language requiring the commissioner within 5 days of receipt of a provider's written evidence in the provider's defense to either cease a withhold or respond to a provider's submission.

Paragraph (g) is existing language specifying the circumstances under which the commissioner must cease to withhold or reduce payments, except new language limits the withhold or reduction to 60 days.

Section 11 contains recodified language currently codified as section 256B.064, subdivision 2, paragraph (d), second sentence, that stipulates any withheld money is forfeit to the commissioner upon a conviction. This section contains no policy changes from existing law.

Section 12 makes technical and conforming changes related to the recodification and modernization of section 256B.064.

Section 13 makes technical and conforming changes related to the recodification and modernization of section 256B.064.

Section 14 makes technical and conforming changes related to the recodification and modernization of section 256B.064.

Section 15 directs the commissioner of human services to establish a medical assistance program integrity advisory board to oversee medical assistance program integrity efforts, evaluate the efforts, and provide recommendations on ways to improve medical assistance program integrity.

Section 16 requires the commissioner of human services to make recommendations to the legislature to enhance provider enrollment screening standards related to the high-risk provider's regulatory knowledge, operational readiness, internal controls, financial liquidity and solvency, and capacity to comply with state and federal Medicaid requirements.

Section 17 requires the commissioner of human services to make recommendations to the legislature to modernize program integrity infrastructure.

Section 18 requires the commissioner to contract with a third-party research entity to identify within high-risk services structural incentive misalignments; undue compliance burdens on good-faith providers; regulatory and billing ambiguities; and gaps in utilization controls.

Section 19 requires the commissioner to recommend methods to strengthen fraud deterrence and promote (1) clarity, (2) proportionality based on the severity of an infraction, (3) provider education, (4) client protection, and (5) continuity of care.

Section 20 is an appropriation to the attorney general for additional staff in the Medicaid Fraud Control Unit.

ARTICLE 2

Article 2 is an amended version of SF 4222 as introduced. Large portions of this article are a recodification of section 256B.04, subdivision 21 – Provider enrollment.

Sections 1, 2 and 3 contain technical conforming changes that update cross-references to conform to the recodification.

Section 4 requires the commissioner to include in the commissioner's end of year report a full account of all pre-enrollment, postenrollment, and unannounced site visits to medical assistance provider enrollees and enrollment applicants.

Section 5 strikes most of the current provider enrollment language in Minnesota Statutes, section 256B.04, subdivision 21, which is recreated in proposed new statutory sections 256B.044 to 256B.0445. The reference to paragraphs in following section summaries are references to the paragraphs of section 256B.04, subdivision 21 from which recodified language is taken.

> **NOTE:** The author has also proposed policy changes to the provider enrollment language and the policy changes are incorporated into the section summaries.

Section 6 adds 256B.044, PROVIDER ENROLLMENT.

> **Subdivision 1 - Designating categorical risk levels** contains language from the second half of paragraph (j) and contains one technical update to the language related to rulemaking. This subdivision contains no policy changes from existing law.
>
> **Subdivision 2 – Required verifications and checks** adds new language specifying the actions the commissioner must take and the information the commissioner must verify before approving an applicant for enrollment as a medical assistance provider
>
> **Subdivision 3 – Required background studies** contains consolidated background study language from paragraphs (a) and (k) as well as new language to:
>
> - expand the fingerprint requirement to officers, directors, agents, managing employees and other persons with operational or managerial control of the provider;
> - clarify that failure to submit any information necessary for a required background study is grounds for denial or termination of provider enrollment in medical assistance; and
> - clarify that an individual or provider is excluded from medical assistance provider enrollment if any individual or provider subject to a background study is disqualified or excluded from any federal health care program.

Subdivision 4 - Service location enrollment contains language from the second sentence of paragraph (a) as well as new language:

- defining "provider-controlled location";
- requiring approval from the commissioner before billing for services provided at an enrolled location;
- specifying exceptions to locations where direct care is provided that do not need to be enrolled locations;
- authorizing sanctions under 256B.064 for a provider failing to enroll a location required to be an enrolled location.

Subdivision 5 – Site visits contains on-site inspection language from the first half of paragraph (j) as well as new language:

- specifying the schedule of site visits; and
- authorizing the commissioner to deny, suspend, or terminate medical assistance provider enrollment is an enrollment applicant or enrollee fails to permit a required site visit.

Subdivision 6 – Surety bonds contains amended surety bond language from paragraph (m). The amended language removes the commissioner's discretion to require a surety bond purchase under the current law conditions.

Subdivision 7 – Financial capacity is new language requiring an enrolled provider to demonstrate sufficient financial capacity to operate, repay improper payments, and make payroll for 90 days

Subdivision 8 – Compliance programs contains expanded compliance program language paragraph (g).

Subdivision 9 – Incomplete provider enrollment applications amends the language from third sentence of paragraph (a) by removing the commissioner's discretion to deny enrollment if a provider fails to submit a complete applications within 60 days of the commissioner's request for additional information.

Subdivision 10 – Correspondence and notification amends the correspondence language from paragraph (e) by removing the commissioner's discretion to use a providers MN-ITS mailbox.

Section 7 adds 256B.0441, PROVIDER REVALIDATION and contains the revalidation language from paragraphs (b) and (c) as well as new language:

- requiring all high-risk providers to be revalidated every three-years;
- requiring the commissioner to revalidate providers more frequently if required by federal law or to protect program integrity;

- requiring the commissioner to provide notice to providers that 30-days prior to revalidation the provider will be subject to unannounced visit;
- reduce from 30 to 14 days the length of time the commissioner has to inform the provider that the provider has failed to submit the required revalidation information and reduce from 30 to 14 days the length of time the provider has to comply;
- reduce from 30 to 28 days the length of time a provider has to remediate any deficiency discovered at the time of revalidation and reduce from 60 to 15 days the commissioner's notice to a provider that the commissioner will terminate the provider's enrollment.

Section 8 adds 256B.0442, PROVIDER ENROLLMENT SUSPENSIONS AND TERMINATIONS and contains the provider enrollment suspension and termination language from paragraphs (d), (h), and (i), as well as new or amended language that:

- removes the commissioner's discretion to suspend a provider's ability to bill for noncompliance;
- authorizes the commissioner to suspend a provider's ability to bill immediately and clarifies that the commissioner may impose additional sanctions;
- in subdivision (3), clauses (1), (2), and (4) to (7) expands the circumstances under which the commissioner must deny or terminate medical assistance provider enrollment.

Section 9 adds 256B.0443, PROVIDER PAYMENT WITHHOLDS UPON INITIAL ENROLLMENT and contains the payment withhold authority from paragraph (f).

Section 10 adds 256B.0444, ENROLLMENT MORATORIUM FOR HIGH-RISK PROVIDERS, which is new language similar to the authority given the commissioner during the 2025 special session to implement licensing moratoria. Under the proposal in this section the commissioner is authorized to implement a medical assistance provider enrollment moratorium for up to 24 months for any provider type that is designated high-risk. Before the moratorium is lifted, the commissioner must revalidate all existing providers of that type.

Section 11 adds 256B.0445, ADDITIONAL PROVIDER ENROLLMENT REQUIREMENTS FOR SPECIFIC PROVIDER TYPES.

Subdivision 1 - Durable medical equipment provider or supplier contains the durable medical equipment provider or supplier language from paragraph (l).

Subdivision 2 - Providers licensed by the commissioner of human services contains a rewritten version of the compliance officer requirement for 245A licensed providers from paragraph (g).

Subdivision 3 - Providers licensed by the commissioner of health contains a rewritten (and corrected) version of the compliance officer requirements for 144A or 144G licensed providers from paragraph (g).

Sections 12, 13, and 14 contain technical conforming changes that update cross-references to conform with the recodification.

Section 15 is a direction to the commissioner of human services to use the good cause exemption to amend Minnesota Rules by modifying a cross reference to the Code of Federal Regulations in the way specified.