

# Legislative Session Review: 2026



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## LINKS TO FULL BILL LANGUAGE

[CCRSF4476: Human Services Program Integrity Finance Omnibus Bill](#)

[SF 476, 4th Engrossment: Human Services Omnibus Policy Bill](#)

## Introduction: Peaks and Valleys

ARRM came into this legislative session anticipating an uphill battle. Following accusations at the state and federal levels of widespread fraud in Medicaid programs in Minnesota that dominated headlines for much of November, December, and January, human services policy was in the spotlight in a way we have not seen in recent memory. And considering that the fraud issue was paired with widespread protests across the Metro area regarding the presence of federal immigration officials, renewed discussions of gun control following attacks on legislators last summer and a school shooting in Minneapolis last fall, and broader conversations about the integrity of state programs, we knew that this year's shortened legislative session would be a marathon. Ultimately, while there were several measures of concern that ultimately made their way into the final bills—and some of our priorities that did not make the final cut—we are grateful for the thoughtful approach legislative leaders took in crafting the final Human Services bills this session.

This report details all of the policies passed this session that are relevant to home and community-based services in Minnesota. The two bills ARRM has analyzed, the Human Services Program Integrity Finance Omnibus Bill and the Human Services Omnibus Policy Bill, are substantial bills with numerous provisions. We want to highlight here a few provisions that were of particular interest to providers throughout the session:

- We are heartened by the changes made to Individualized Home Supports with Training (IHS-T), changing the six-hour daily cap to a more flexible monthly cap and removing the three-hour consecutive limit. This was passed in large part thanks to the tireless advocacy of numerous ARRM members.
- ARRM's policy priority to expand flexibility around annual training was included in the final bill, allowing direct care staff to complete required annual training up to 90 days after the required date.
- Another ARRM policy priority that was passed requires the Department of Human Services to issue interpretive guidance within 120 days of the effective date of any statutory changes, waiver plan amendments, administrative rulings, or court decisions at the state or federal levels, which will help ensure new policies are applied consistently across the state.
- Amidst the intense scrutiny on human services and broader conversations about fraud, ARRM worked hard to ensure that any program integrity requirements passed did not unintentionally harm legitimate providers and the people they serve.
- ARRM helped prevent several detrimental policies put forth in the Governor's proposed human services budget. In particular, the Governor proposed a 2% annual cap on inflationary adjustments and a 351-day billing cap on residential services, both of which would be incredibly harmful to providers. ARRM's advocacy efforts helped keep the provision out of the final bill language.
- ARRM was disappointed by the cuts to human services, amounting to an additional \$300 million on top of the \$1 billion passed last session. We are concerned about the future of Family Residential Services (FRS) after the legislature declined to include changes to FRS rate tiers this session. ARRM also plans to support ICS providers through the substantial changes coming to that service.

ARRM encourages providers to continue communicating with their legislators around policies that put additional strain on the system, and to get involved with ARRM's advocacy efforts as we plan our legislative agenda for 2027.

# PART ONE

## Human Services Program Integrity Finance Omnibus Bill

### Continuity of Care

Establishes new responsibilities to ensure the continuity of care when a provider determines it can no longer provide services.

#### Provider Duties:

- ➔ Notify each recipient; each recipient's responsible party, if applicable; the lead agency; and the commissioner as soon as possible but no later than 30 days before terminating services to each recipient
- ➔ Fully cooperate with the commissioner and lead agency in supporting each recipient in transitioning to another provider of each recipient's choice
- ➔ Provide each recipient with a copy of the relevant recipient bill of rights or recipient protections, if applicable, as soon as possible but no later than 30 days before terminating services

#### Lead Agency Duties:

- ➔ Inform the appropriate ombudsperson's office for each recipient currently receiving services, if applicable, that the recipient's service provider is subject to an administrative action or is experiencing a serious operational event
- ➔ Directly notify each recipient who receives services from the provider that the recipient's service provider is subject to an administrative action or is experiencing a serious operational event
  - » When a service provider provides notice that it is unable to continue to provide services to a recipient due to an administrative action or serious operational event, the lead agency must assist the provider in developing a continuity of care plan to facilitate the recipient's transition to another provider of the recipient's choice. The continuity of care plan must be developed through a person-centered process and include alternative service options, settings, and service providers with known service capacity. The lead agency must complete and receive approval from the recipient of the continuity of care plan no later than 14 days following the notification.
  - » When a lead agency identifies a recipient's transition as a complex transition, the lead agency must develop a complex transition plan and cooperate with and provide information to the commissioner as requested so that the commissioner can ensure each recipient receives continuity of medically necessary services and supports through a safe and orderly transition to an appropriate alternative service provider

Commissioner's Duties: When the commissioner takes an administrative action against a provider, the commissioner must endeavor to contact the lead agency administering services for potentially affected recipients as soon as practicable and no later than 30 days prior to the administrative action becoming effective. The commissioner must ensure that the lead agency is taking appropriate steps to ensure continuity of care and that affected recipients will:

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## *Continuity of Care, continued*

- ↳ Continue to receive needed medically necessary services and supports
  - ↳ Be given free choice of service, service setting, and service provider if the recipient transfers to another service, service setting, or service provider
  - ↳ Secure safe and stable housing
    - » The commissioner must establish and maintain a continuity of care team to support continuity of care efforts by lead agencies and providers. The continuity of care team must include personnel from across the Department of Human Services with roles in monitoring and supporting providers and lead agencies, establishing standards for continuity of care, supporting transition planning processes for individuals with a complex transition designation, and overseeing licensing and program integrity efforts. The commissioner may include personnel from other state agencies and housing support providers necessary to effectively carry out the duties of the continuity of care team.
    - » The continuity of care team must provide support, oversight, and direction to lead agencies and providers when a recipient's transition is identified as a complex transition
- **Effective Date:** July 1, 2026
  - **Bill Reference:** CCRSF4476, Article 1, Section 1

## **Complex Transitions**

The lead agency must work with the provider and commissioner to identify each recipient whose transition is a complex transition. The lead agency and provider must submit to the commissioner a complex transition plan for each recipient.

The plan template must include data fields to collect at least the following information:

- ↳ Recipient's name and acuity level
  - ↳ Stabilization actions to be taken to prevent gaps in care and housing
  - ↳ Names, contact information, and known capacity of alternative providers
  - ↳ Transition timelines, transportation, and handoff procedures
  - ↳ A communication plan for each recipient, the recipient's family, and the recipient's guardian, if applicable, including language access
  - ↳ Steps to be taken to coordinate with lead agencies, case managers, and ombudsperson offices, when applicable
- **Effective Date:** July 1, 2026
  - **Bill Reference:** CCRSF4476, Article 1, Section 2

## **Housing Support Capacity Building Grants**

The commissioner of human services must establish capacity-building grants for housing support providers assisting recipients of medical assistance home and community-based services, including but not limited to integrated community supports, to prevent homelessness and institutionalization. The commissioner must award at least one grant to a qualified grant recipient located outside of the seven-county metropolitan area.

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## Housing Support Capacity Grants, continued

Capacity-building grants may be used for:

- ↳ Administrative expenses
  - ↳ The assessment of eligible housing assistance benefits
  - ↳ Housing transition assistance, including supports required due to a change in an individual's medical assistance services or provider
  - ↳ The development of regional or collaborative housing support models that enable housing support providers to better support individual choice and access to community-integrated housing options
- **Effective Date:** July 1, 2026
  - **Bill Reference:** CCRSF4476, Article 1, Section 6

## Direction to Commissioner, Continuity of Care Policies and Procedures

The commissioner of human services must develop policies and procedures that lead agencies must follow when developing, implementing, monitoring, and closing a complex transition plan under Minnesota Statutes, section 256B.046. The policies and procedures must include timelines, checklists, and mandatory follow-up with all parties involved in the development and implementation of the plan. The policies and procedures must include documentation requirements sufficient to demonstrate that the planning process and implementation was person-centered and prioritized the needs and informed choice of the service recipient.

- **Effective Date:** July 1, 2026
- **Bill Reference:** CCRSF4476, Article 1, Section 7

## Application of Licensure

An applicant or license holder that elects to receive reimbursement for services designated as high-risk must provide a notarized attestation stating whether they received any assistance from an unaffiliated business or consultant in preparing the application, renewal, or any documentation or written policies submitted or maintained.

- **Effective Date:** July 1, 2026
- **Bill Reference:** CCRSF4476, Article 3, Section 7

## Department of Human Services HCBS Early and Often Licensure and Compliance Team

The commissioner must establish and maintain a home and community-based services early and often licensure and compliance team with sufficient staff and resources to:

- ↳ Provide technical assistance in submitting license applications under 245A and 245D, and provider enrollment applications under 256B
- ↳ Conduct initial, scheduled visits 3 months after the effective date of an initial license
- ↳ Conduct 3 unscheduled visits between 6 and 18 months after the effective date of an initial license

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If a license holder is found to be out of compliance of a law, rule, or regulation, and the health, safety, or rights of a person supported are not in imminent danger, the license holder may continue to provide services while working to correct the deficiencies. None of these provisions limit the commissioner's authority to suspend, revoke or sanction a license holder.

- **Effective Date:** July 1, 2026
- **Bill Reference:** CCRSF4476, Article 3, Section 9

## **Department of Human Services HCBS Provider Support and Technical Assistance Team**

The commissioner must establish and maintain a home and community-based services provider support and technical assistance team with sufficient staff and resources to:

- ↳ Serve as a provider liaison and help desk
- ↳ Develop training and onboarding materials
- ↳ Collect data on provider challenges
- ↳ Coordinate functions such as information technology, licensing, provider enrollment, service delivery oversight, and program integrity oversight
- ↳ Make recommendations on the operations of the department or the design and implementation of services

- **Effective Date:** July 1, 2026
- **Bill Reference:** CCRSF4476, Article 3, Section 13

## **Medical Assistance Education Program**

The commissioner must provide information to all medical assistance enrollees on:

- ↳ Their benefits, rights, and responsibilities
- ↳ How to access and receive services
- ↳ Their right to file complaints, grievances, and appeals
- ↳ General information about preventing fraud and abuse
- ↳ How to report concerns to the department and managed care organizations about fraud and abuse

All information must be in plain language, be culturally and linguistically appropriate, and comply with federal law on enrollee communications.

When an enrollee's use of services results in abusive or fraudulent billing, the commissioner must notify the enrollee about the availability of this information, and may provide additional educational information.

- **Effective Date:** July 1, 2026
- **Bill Reference:** CCRSF4476, Article 3, Section 16

## Preenrollment Assessment

Before enrolling a provider or agency, the commissioner may complete a preenrollment risk assessment to confirm eligibility and ability to meet licensing requirements. The commissioner must use a risk-score framework that identifies service-specific fraud risk indicators, including organizational readiness, financial stability, compliance history, and addressing service necessity. Based on the assessment score, the commissioner may deem the applicant ineligible and deny or rescind enrollment, which must be in writing. The applicant may request reconsideration in writing within 30 business days, and the commissioner must notify the applicant of the final decision.

A provider that was enrolled before July 1, 2026, that has billed for services on or after January 1, 2025 must receive a positive risk assessment no later than July 1, 2027, to remain eligible. A provider that was enrolled before July 1, 2026, that has not billed for services on or after January 1, 2025, must receive a positive risk assessment no later than July 1, 2026, to remain eligible. A provider that was deemed ineligible under this section may regain eligibility after a positive assessment.

- **Effective Date:** July 1, 2026
- **Bill Reference:** CCRSF4476, Article 3, Section 17

## Provider Enrollment

**Required verifications and checks:** Prior to making an enrollment determination and periodically thereafter, the commissioner must:

- ↳ Verify that the provider meets federal and state requirements for the provider type
- ↳ Conduct license verifications in Minnesota and any other states where the provider is or was licensed
- ↳ Conduct database checks preenrollment and postenrollment to ensure that the provider continues to meet enrollment criteria
- ↳ Confirm that the provider and any disclosed owners, managing employees, or controlling individuals are not excluded from any health care programs, including Medicare and Medicaid
- ↳ Verify the provider's NPI, tax identification number, and business registration status

**Required background studies:** The commissioner must conduct a background study for each individual with an ownership or control interest, or who is an officer, director, agent, managing employee or other person with operational or managerial control. Fingerprint-based studies are required when mandated by federal law, or for providers designated as moderate- or high-risk. The commissioner may conduct postenrollment background studies as necessary. A provider may be denied enrollment or be disenrolled for failure to submit information required for a background study, and enrollment must be denied or terminated if a provider or individual is disqualified or excluded from any federal health care program.

**Service location enrollment:** A provider must enroll each provider-controlled location where direct services are provided. Separate enrollment is not required for services provided in a recipient's home or community setting, telehealth services delivered from an enrolled site, compliant mobile services, or other federally permissible exemptions. Failure to enroll required locations may result in sanctions.

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**Surety bonds:** The commissioner must require a provider to purchase a surety bond naming the Department of Human Services as an obligee as a condition of initial enrollment, reenrollment, revalidation, reinstatement, or continued enrollment. Upon new enrollment, or if the provider's medical assistance revenue in the previous calendar year is less than or equal to \$300,000, the provider must purchase a surety bond of \$50,000. If the provider's medical assistance revenue in the previous calendar year is greater than \$300,000, the provider must purchase a surety bond of \$100,000. The surety bond must be purchased new annually, and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions from a surety bond must occur within six years from the date the debt is affirmed by a final agency decision. This requirement does not apply if the provider currently maintains a surety bond under the requirements under section 256B.0659, 256B.0701, or 256B.85.

**Financial capacity:** As a condition of enrolling in medical assistance, the commissioner must require that a provider attest to sufficient financial capacity to operate. The commissioner determines the form and manner of the attestation.

**Compliance programs:** The commissioner may require that a provider maintain a compliance program consistent with federal program integrity guidance. If an enrolled provider is required to designate an individual as the compliance officer, the provider must appoint an individual responsible for implementing and overseeing the compliance program. At a minimum, the compliance program must include policies and procedures designed to:

- Ensure adherence to federal and state laws and program requirements, and prevent the submission of improper claims
- Train employees, agents, contractors, and subcontractors, including billing personnel, on applicable federal and state laws and program requirements
- Establish procedures for receiving, investigating, and responding to allegations of improper conduct and for implementing corrective actions
- Use auditing, monitoring, or other evaluation techniques to assess ongoing compliance
- Promptly report to the commissioner any credible evidence of violations of federal and state laws or regulations
- Report and return identified overpayments within 60 days after discovery or by the date any corresponding cost report is due, whichever is later

- **Effective Date:** July 1, 2026
- **Bill Reference:** CCRSF4476, Article 3, Section 18

## **Provider Revalidation**

The commissioner must revalidate each provider at least every 5 years, or certain provider types and all providers designated as high-risk at least every 3 years. The commissioner must also conduct revalidation of a provider more frequently when required under federal law or when necessary to protect program integrity.

The commissioner must provide 30 days' notice of the revalidation due date, including instructions for revalidation, a list of materials the provider must submit, and a notice about the possibility of an unannounced site visit. If a provider fails to submit all required materials or satisfy the requirements by the due date, the commissioner must notify the provider of the deficiency within 14 days after

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## *Provider revalidation, continued*

the due date and allow the provider an additional 14 days from the notification date to comply. If a provider fails to remedy a deficiency within the additional 28-day time period, the commissioner must give 15 days' notice of termination and immediately suspend the provider's ability to bill. The commissioner's decision to suspend the provider's ability to bill is not subject to an administrative appeal. For a provider designated moderate- or high-risk, the commissioner must conduct unannounced site visits at each of the provider's enrolled locations no more than 30 days prior to the provider's revalidation due date. A provider must demonstrate financial capacity as a requirement of revalidation.

- **Effective Date:** July 1, 2026
- **Bill Reference:** CCRSF4476, Article 3, Section 19

## **Provider Enrollment, Suspensions and Termination**

**Suspension of billing privileges:** If a provider fails to comply with any individual provider requirement or condition of participation, the commissioner may suspend the provider's ability to bill until the provider comes into compliance. The commissioner may immediately impose a suspension under this subdivision when necessary to protect public funds or ensure program integrity. A suspension under this subdivision does not limit the authority of the commissioner to issue any other sanction authorized under federal or state law. The commissioner's decision to suspend a provider's ability to bill is not subject to an administrative appeal.

**Revocation for lack of documentation:** The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by the provider when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure to maintain documentation or provide access to documentation on more than one occasion. Nothing in this subdivision limits the authority of the commissioner to sanction a provider under section 256B.064. Subd. 3.

**Mandatory denial or termination of enrollment:** The commissioner must terminate or deny the enrollment of a provider when an individual with a five percent or greater direct or indirect ownership interest in the provider does not submit timely and accurate information and cooperate with the screening methods, or has been convicted of a criminal offense related to the individual's involvement in a government health care program in the last ten years.

The commissioner must also terminate or deny the enrollment of a provider when the provider, or an individual with a five percent or greater direct or indirect ownership interest in the provider, was terminated from participation in a government health care program and is currently included in the federal termination database, or the provider or individual fails to submit timely or accurate information, or the provider or individual fails to submit sets of fingerprints within 30 days of a request, or the provider fails to permit access to provider locations for any site visits, or CMS or the commissioner determines that the provider has falsified any information provided on the application or cannot verify the identity of any provider applicant.

- **Effective Date:** July 1, 2026
- **Bill Reference:** CCRSF4476, Article 3, Section 20

## Payment Withholds for High-Risk Providers

If the commissioner or the Centers for Medicare and Medicaid Services designates a provider type as high-risk the commissioner may withhold payment from providers within that category upon initial enrollment for a 90-day period.

- **Effective Date:** July 1, 2026
- **Bill Reference:** CCRSF4476, Article 3, Section 21

## Enrollment Moratorium for High Risk Providers

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

The commissioner may grant exceptions to a moratorium and must make publicly available the processes and criteria the commissioner will use to grant exceptions.

- **Effective Date:** July 1, 2026
- **Bill Reference:** CCRSF4476, Article 3, Section 22

## Additional Provider Enrollment Training Requirements for High Risk Providers

Effective January 1, 2027, before applying for enrollment or reenrollment as a medical assistance provider, an agency applying to provide services designated by the commissioner as high-risk must require all owners of the agency who are active in the day-to-day management and operations of the agency and all managerial and supervisory employees to complete compliance training. All individuals required to complete training under this subdivision must repeat the training prior to the agency's revalidation as a medical assistance provider.

New owners active in day-to-day management and operations of the agency and new managerial and supervisory employees of the agency must complete compliance training under this subdivision within 30 calendar days of becoming an owner of or beginning employment with the agency and prior to conducting any management or operations activities for the agency. If an individual moves to another agency providing the same service and serves in a similar ownership or employment capacity, the individual is not required to repeat the training.

The training must include the following topics, adapted as necessary for each provider type:

- ↳ State and federal program billing, documentation, and service delivery requirements
- ↳ Enrollment requirements
- ↳ Provider program integrity, including fraud prevention, detection, and penalties
- ↳ Fair labor standards
- ↳ Workplace safety requirements
- ↳ Recent changes in service requirements

- **Effective Date:** July 1, 2026
- **Bill Reference:** CCRSF4476, Article 3, Section 24

## Enhanced Prepayment Review

Beginning April 1, 2027, the commissioner must conduct enhanced prepayment review under this section of at least 65 percent of all fee-for-service claims.

The commissioner must provide written notice to a provider placed under enhanced prepayment review at least 15 days before the review is implemented. The notice must include:

- ↳ the basis for review
  - ↳ the effective date of review
  - ↳ the standards the commissioner will use to determine when the provider, covered service, or claims will no longer be subject to enhanced prepayment review
- **Effective Date:** July 1, 2026
  - **Bill Reference:** CCRSF4476, Article 3, Section 24

## Postpayment Review

The commissioner may conduct postpayment review of claims, encounters, cost reports, rate submissions, and other billings submitted for payment or reimbursement under this chapter to identify improper payments and recover payments made in violation of state or federal law or program requirements.

If postpayment review identifies an overpayment or other noncompliance with medical assistance payment requirements, the commissioner may recover payments and impose sanctions in accordance with section 256B.064 and other applicable laws.

- **Effective Date:** January 1, 2027
- **Bill Reference:** CCRSF4476, Article 3, Section 26

## Imposition of Fines

The commissioner may order an individual or entity to forfeit a fine for failure to fully document services according to standards in chapter 256B.064 and Minnesota Rules, chapter 9505. The commissioner may assess fines if specific required components of documentation are missing. The fine for incomplete documentation equals 20 percent of the amount paid on the claims for reimbursement submitted by the individual or entity, or up to \$5,000, whichever is less.

- **Effective Date:** The date following enactment
- **Bill Reference:** CCRSF4476, Article 3, Section 34

## Mandatory Suspension or Termination after exclusion from Participation in Medicare

The commissioner must suspend or terminate an individual's or entity's participation in the program without providing advance notice and an opportunity for a hearing when the suspension or termination is required because of the individual's or entity's exclusion from participation in Medicare.

- **Effective Date:** The date following enactment
- **Bill Reference:** CCRSF4476, Article 3, Section 35

## Imposition of Withholding or Reduction of Payments without Prior Notice

The commissioner must temporarily withhold or reduce payments to an individual or entity without providing advance notice of the withholding or reduction if either of the following occurs:

- The individual or entity is convicted of a crime
- The commissioner determines there is a credible allegation of fraud for which an investigation is pending under the program

The commissioner must send notice of the withholding or reduction of payments within five days of withholding or reducing payments unless requested in writing by a law enforcement agency to temporarily withhold the notice

- **Effective Date:** The date following enactment
- **Bill Reference:** CCRSF4476, Article 3, Section 36

## Administrative Review of Temporary Payment Withhold or Reduction

Upon receipt of a notice that a payment withhold or reduction is imposed, an individual or entity may request a review by filing with the commissioner a written request for an administrative review. The review request must be received by the commissioner no later than 30 days after the date the notification of the payment withhold or reduction was mailed to the individual or entity. The review request must specify the reason the payment withholding or reduction decision is in error and clearly request a review. The commissioner must refer the review request to the Court of Administrative Hearings within ten business days of receiving the review request.

- **Effective Date:** July 1, 2026
- **Bill Reference:** CCRSF4476, Article 3, Section 37

## Withholding or Reduction of Payments: Legal Processes

The commissioner must submit evidence to an administrative law judge whenever a payment withhold or reduction has been in place for 90 days to determine whether an investigation is actively being pursued. The judge will provide a recommendation as to whether the withhold or reduction should be continued, and the commissioner's decision is final and not subject to appeal or reduction. This process must be repeated every 90 days, and within 10 business days of each review, the commissioner must provide notice to the individual or entity being reviewed, including the judge's recommendation.

- **Effective Date:** July 1, 2026
- **Bill Reference:** CCRSF4476, Article 3, Section 38

## Remittance Advice Monetary Recovery

The commissioner may use the remittance advice process as sole notice to a vendor or provider when seeking monetary recovery, and the payments at issue must be withheld. Providers may seek reconsideration within 30 calendar days, but that will not stay the withholding.

- **Effective Date:** July 1, 2026
- **Bill Reference:** CCRSF4476, Article 3, Section 46

## Mandatory Compliance Training for Currently Enrolled High-Risk Medical Assistance Providers

The owners and employees of any medical assistance provider agency designated as high-risk, and enrolled before January 1, 2027, must complete initial compliance training by January 1, 2028.

- **Effective Date:** July 1, 2026
- **Bill Reference:** CCRSF4476, Article 3, Section 63

## Withholding Payments: Commissioner Authority

Provides the commissioner with additional reasons to withhold payments, including:

- ↳ The individual, the entity, or an associated individual or entity was convicted of a crime, in state or federal court, for an offense that involves fraud or theft against a program administered by the commissioner or another state or federal agency
- ↳ The provider is operating after a state or federal agency orders the suspension, revocation, or decertification of the provider's license or certification, or if the provider is subject to a temporary immediate suspension, regardless of whether the action is under appeal
- ↳ The provider, vendor, individual, associated individual, or associated entity, including those receiving funds under any contract or registered program, has a background study disqualification under section 245C.15, subdivisions 1 to 4b, that has not been set aside and for which no variance has been issued

- **Effective Date:** July 1, 2026
- **Bill Reference:** CCRSF4476, Article 4, Section 2

## Notification of Affected Municipalities

Requires the commissioner to give the affected municipality or other political subdivision written notice of the issuance of a new licensed program no later than five days after issuing the license, excluding weekends and holidays. The written notice must include the prospective license holder's name and contact information, the license type and capacity, and the proposed address of the licensed facility or program.

- **Effective Date:** July 1, 2026, and applies only to licenses issued on or after the effective date
- **Bill Reference:** CCRSF4476, Article 9, Section 2

## Meeting Fire and Safety Codes

At the request of a county or local unit of government, the commissioner may delegate to a county agency or local unit of government the commissioner's or local agency's authority to inspect an existing residential program serving six or fewer persons for compliance with zoning ordinances and applicable physical plant licensing requirements.

*continued*

## *Meeting fire and safety codes, continued*

A county agency or local unit of government that conducts inspections under this subdivision must not inspect a residential program more frequently than annually, except a follow-up inspection is permitted before the next annual inspection to verify correction of a violation discovered during the most recent inspection.

The commissioner must ensure that laws, rules, and codes are uniformly enforced throughout the state by reviewing at least every four years each county agency and local unit of government conducting inspections under this subdivision for compliance with this subdivision and other applicable laws and rules.

- **Effective Date:** January 1, 2027
- **Bill Reference:** CCRSF4476, Article 9, Section 3

## **Colocation of Certain Settings**

Newly licensed settings must not be located on the same property or on an adjoining property of any existing community residential setting, any existing adult foster care setting, any existing setting providing family residential services to an adult, any existing setting providing customized living services with a resident capacity of six or fewer, any existing setting providing 24-hour customized living services with a resident capacity of six or fewer, or any existing assisted living facility licensed under chapter 144G with a resident capacity of six or fewer.

- **Effective Date:** July 1, 2026
- **Bill Reference:** CCRSF4476, Article 9, Section 4

## **ICS License Moratorium**

The commissioner must not issue an initial license authorizing integrated community supports, and must not approve a license change adding integrated community supports to an existing license under this chapter. The commissioner may approve exceptions to the moratorium only when specific requirements are met and statewide and regional capacity for integrated community supports based on needs determination processes are considered. A determination is not subject to appeal.

- **Effective Date:** July 1, 2027
- **Bill Reference:** CCRSF4476, Article 9, Section 5

## **LTSS Loan Program**

The LTSS Loan Program, which was originally established in 2023 and expanded in 2024 to support Long Term Services and Support programs at risk of closure, is repealed. The repeal of this loan program saves the state approximately \$70 million.

- **Effective Date:** July 1, 2026
- **Bill Reference:** CCRSF4476, Article 9, Section 7, 8, and 9

## Interpretive Guidelines for Disability Waiver Regulation

The commissioner must develop and publish interpretive guidelines within 120 calendar 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 services licensed under chapter 245D, authorized under section 256B.092 or 256B.49, or reimbursed under section 256B.4914.

- **Effective Date:** July 1, 2028
- **Bill Reference:** CCRSF4476, Article 9, Section 11

## Billing Limits: Chore, Homemaker, Personal Emergency Response Systems

Sets the following billing limits:

- ↳ Chore services: a maximum of 24 units per week per recipient, where a unit is defined as a 15-minute increment
  - ↳ Homemaker services: cleaning and home management may be provided for a maximum of 16 hours combined per week per recipient
  - ↳ Personal emergency response system services, a maximum of one unit per month per recipient
- **Effective Date:** January 1, 2027
  - **Bill Reference:** CCRSF4476, Article 9, Section 19

## Billing Limits: EIDBI

Sets the following billing limits:

- ↳ Intensive services: 40 hours per week per recipient
  - ↳ Travel: two hours per day per recipient
  - ↳ Observation and direction: 20 hours per week per recipient
  - ↳ Individual treatment and planning: 300 units per year per recipient
- **Effective Date:** January 1, 2027
  - **Bill Reference:** CCRSF4476, Article 9, Section 19

## Billing Limits: Various Areas

Sets the following billing limits:

- ↳ Assistive technology authorized under section 256B.092, a maximum of \$10,000 annually per recipient
  - ↳ Chore services, a maximum of 24 units per week per recipient, where a unit is defined as a 15-minute increment
  - ↳ Homemaker services, cleaning and home management may be provided for a maximum of 16 hours combined per week per recipient
  - ↳ Family training and counseling, a maximum of two hours per week per recipient
  - ↳ Independent living skills, a maximum of six hours per day per recipient
  - ↳ Personal emergency response system services, a maximum of one unit per month per recipient
- **Effective Date:** July 1, 2027
  - **Bill Reference:** CCRSF4476, Article 9, Section 21

## Prohibition on Room and Board Payments

The bill includes federal compliance language that states that a provider must not use medical assistance money to pay for room and board, including but not limited to rent, mortgage payments, utilities, property taxes, homeowners association fees, or any other housing-related cost.

Language goes on to state that payment for room and board is permitted when explicitly included as part of a service authorized in a federally approved home and community-based services waiver.

ARRM advocated for this last provision to ensure that providers could remain in compliance with the requirements on 245D.22.

- **Effective Date:** January 1, 2027
- **Bill Reference:** CCRSF4476, Article 9, Section 22

## ICS Direct Staffing Wage

Creates a new direct staffing wage in the DWRS rate framework methodology for ICS, effective October 1, 2027.

- **Effective Date:** October 1, 2027
- **Bill Reference:** CCRSF4476, Article 9, Section 24

## CRS 1-1 Staffing Limits

Acuity-based limits for individual staffing hours in a Community Residential Setting are established. An individual's acuity level is determined through their MnCHOICES assessment. The limits are as follows, with an exception process being established:

- ↳ Zero individual hours per day for people assessed for case mixes A, C, and L
- ↳ No more than six individual hours per day for people assessed for case mixes B, D, and F
- ↳ No more than 16 individual hours per day for people assessed for case mixes E, G, I, J, and K
- ↳ No more than 24 individual hours per day for people assessed for case mix H or residing in a community residential setting licensed for one person, regardless of case mix level
- ↳ The commissioner must provide an exception process to the limits for individuals with extraordinary needs who might otherwise end up in institutional settings without additional authorized individual hour inputs

- **Effective Date:** July 1, 2027
- **Bill Reference:** CCRSF4476, Article 9, Section 26

## ICS Maximum Hours

Establishes maximum allowable in-person and remote service hours for ICS based on the recipient's case mix classification as follows:

- ↳ Two hours per day for classifications A, C, and L
- ↳ Four hours per day for classifications B, D, and F
- ↳ Six hours per day for classifications E, G, I, J, and K
- ↳ Eight hours per day for classification H

*continued*

## ICS maximum hours, continued

These limits do not limit a person's use of other disability waiver services that may be provided on the same day in alignment with the federally approved waiver. Rate exceptions for individuals with exceptional or complex needs are not prohibited.

- **Effective Date:** January 1, 2027 and expires October 1, 2027
- **Bill Reference:** CCRSF4476, Article 9, Section 27

## Customized Living Payment Change

Customized living monthly service rate limits must equal the monthly service rate limits determined under section 256S.202, subdivisions 1 and 2, multiplied by 126.36 percent.

- **Effective Date:** January 1, 2027, or upon federal approval, whichever is later
- **Bill Reference:** CCRSF4476, Article 9, Section 28

## Integrated Community Supports: Daily

Establishes ICS access services as a distinct DWRS service. It also establishes the rate calculation methodology and component values, including shared staffing hours fixed at 8.

- **Effective Date:** October 1, 2027, or upon federal approval, whichever is later
- **Bill Reference:** CCRSF4476, Article 9, Section 29

## Billing Limits: Day Support

The billing limit for day support services is equal to a maximum of eight hours per day per recipient.

- **Effective Date:** January 1, 2027, or upon federal approval, whichever is later
- **Bill Reference:** CCRSF4476, Article 9, Section 30

## IHS-T Monthly Limit

Language amends the current 6-hour daily cap of IHS-T to a monthly cap and removes the 3-hour consecutive limit for both IHS-T and IHS with Family Training:

- ↳ For individualized home supports with training, a monthly service limit of 182.5 hours
- ↳ For individualized home supports with family training, not more than six total hours per day

- **Effective Date:** January 1, 2027
- **Bill Reference:** CCRSF4476, Article 9, Section 31

## Integrated Community Supports: Unit-Based

Establishes ICS unit-based services with programming as a distinct DWRS service. It also establishes the rate calculation methodology and component values, some of which are different than other unit-based services with programming. This section includes the same maximum allowable in-person and remote hours as Article 9, Sec. 27.

- **Effective Date:** October 1, 2027, or upon federal approval, whichever is later
- **Bill Reference:** CCRSF4476, Article 9, Section 32

## Billing Limit: Night Supervision

The billing limit for awake night supervision and asleep night supervision is equal to a maximum of ten hours per day per recipient, of which no more than eight hours per day may be asleep night supervision.

- **Effective Date:** January 1, 2027, or upon federal approval, whichever is later
- **Bill Reference:** CCRSF4476, Article 9, Section 33

## Billing Limit: Respite

The billing limit for in-home respite services is equal to a maximum of 30 consecutive days per respite occurrence.

- **Effective Date:** January 1, 2027, or upon federal approval, whichever is later
- **Bill Reference:** CCRSF4476, Article 9, Section 34

## Residential Service Documentation Requirements

New documentation requirements for residential services were developed to track staffing hours for each service recipient.

Documentation must include:

- ↳ The name, role, and unique identifier for each staff person who provided services to match records to payroll, time and attendance systems, and any other source documentation
- ↳ The date services were provided
- ↳ The total number of hours of direct support provided
- ↳ Awake overnight staffing hours provided, if applicable
- ↳ Asleep overnight staffing hours provided, if applicable
- ↳ Any other staffing information required by the commissioner

Additional requirements include:

- ↳ A provider must maintain documentation in a manner and format determined by the commissioner for at least six years
- ↳ A provider must submit the documentation to the commissioner annually, in a manner and format determined by the commissioner

*continued*

## Residential service documentation requirements, continued

- ↳ The commissioner must conduct periodic analysis of documentation
- ↳ Based on the analysis, the commissioner may provide recommendations to lead agencies regarding modifications to the rate of a person receiving services, including increases or decreases necessary to align the rate with staffing provided to the person as demonstrated by the submitted historical staffing documentation
- **Effective Date:** January 1, 2029
- **Bill Reference:** CCRSF4476, Article 9, Section 35

*Note: with the delayed effective date, ARRM intends to continue to engage in conversations with legislators and the Department of Human Services about this new requirement.*

## Billing Limit: Transportation

The billing limit for waiver transportation is equal to a maximum of 28 one-way trips per week per participant.

- **Effective Date:** January 1, 2027, or upon federal approval, whichever is later
- **Bill Reference:** CCRSF4476, Article 9, Section 36

## ICS Billing Standards

Establishes service standards and billing criteria for ICS access services, which is defined as onsite or on-call availability of trained staff to address incidental, unplanned support needs. This section includes staff qualifications and documentation requirements.

- **Effective Date:** October 1, 2027, or upon federal approval, whichever is later
- **Bill Reference:** CCRSF4476, Article 9, Section 31

## Administrative Fee Cap

The commissioner must 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.

This limit applies to the following services and other new market rate services as determined by the commissioner:

- ↳ Chore services billed daily
- ↳ Transitional services
- ↳ Transportation

- **Effective Date:** January 1, 2027, or upon federal approval, whichever is later
- **Bill Reference:** CCRSF4476, Article 9, Section 38

## ICS Setting Moratorium

The commissioner must not approve a new integrated community supports setting, or the expansion of an existing setting. The commissioner may approve exceptions to the moratorium only when specific requirements are met. A determination is not subject to appeal.

- **Effective Date:** January 1, 2027
- **Bill Reference:** CCRSF4476, Article 9, Section 39

## Waiver ReImagine

No additional delays for Waiver ReImagine were included in the legislation, but the following provisions were added to the existing statute:

- ↳ Information on an individual's total budget must be provided to the individual at least 12 months prior to the date their services will be subject to the budget.
  - ↳ The commissioner must establish a phased approach to implementing the two-waiver program structure. The commissioner must consult with the Olmstead Implementation Office prior to seeking federal approval to ensure the phased approach promotes community integration and continuity of care.
- **Effective Date:** The date following enactment
  - **Bill Reference:** CCRSF4476, Article 9, Section 51

## Licensing Moratorium Exception

An exception to the moratorium is established for:

- ↳ People receiving customized living or 24-hour customized living services under the brain injury or community access for disability inclusion waiver plans under section 256B.49 and residing in the customized living setting before July 1, 2026, for which a license is required

The exception is available when:

- ↳ The person's customized living services are provided in a customized living service setting serving four or fewer people under the brain injury or community access for disability inclusion waiver plans under section 256B.49 in a single-family home operational on or before June 30, 2026
- ↳ The person's case manager provided the person with information about the choice of service, service provider, and location of service, including in the person's home, to help the person make an informed choice
- ↳ The person's services provided in the licensed foster care or community residential setting are less than or equal to the cost of the person's services delivered in the customized living setting, as determined by the lead agency

The exception is available until June 30, 2027.

- **Effective Date:** July 1, 2026
- **Bill Reference:** CCRSF4476, Article 9, Section 52

## Waiver Case Management Study

The commissioner of human services shall convene a waiver case management advisory working group. The purpose of the working group is to evaluate and make recommendations regarding the quality, workforce sustainability, accountability, and long-term stability of home and community-based waiver case management services. The first meeting of the workgroup must be convened no later than August 1, 2026, with a final report due by September 1, 2027.

In addition, beginning July 1, 2027, the commissioner of human services must evaluate reimbursement rates and lead agency duties associated with home and community-based services (HCBS) case management. The commissioner must develop an updated payment methodology for waiver case management that reasonably covers the cost to provide high-quality, person-centered, and culturally responsive case management services. The final report is due to the legislature by December 15, 2028.

- **Effective Date:** July 1, 2026 (workgroup requirements), and July 1, 2027 (commissioner requirements)
- **Bill Reference:** CCRSF4476, Article 9, Sections 53 and 54

## ICS Reform Study

The commissioner must review the ICS service and evaluate the need for statutory, regulatory, and programmatic reforms. The commissioner must consult with the community in conducting the review and develop recommendations for administrative and legislative changes. An initial report must be submitted to the Legislature by March 1, 2027, and a final report by January 1, 2028.

- **Effective Date:** July 1, 2026
- **Bill Reference:** CCRSF4476, Article 9, Section 55

## Market Rate Study

The commissioner of human services must conduct a market rate study to evaluate the adequacy, sustainability, and equity of payment rates for specific home and community-based services.

The study must include, at a minimum, an analysis of the following services:

- ↳ Employment support services delivered in remote or virtual settings
- ↳ 24-hour emergency assistance
- ↳ Assistive technology
- ↳ Environmental accessibility adaptations
- ↳ Chore services
- ↳ Transitional services
- ↳ Independent living skills training
- ↳ Specialist services, including positive support services and orientation and mobility services

A final report is due to the legislature by February 15, 2027.

- **Effective Date:** The date following enactment
- **Bill Reference:** CCRSF4476, Article 9, Section 56

## MnCHOICES Redesign Working Group

The commissioner of human services shall convene a MnCHOICES redesign working group to develop recommendations related to state provision of MnCHOICES assessments.

The working group shall make recommendations to shift the responsibility and administration of conducting MnCHOICES assessments to the state.

Recommendations must include:

- Defined roles and responsibilities between county, Tribal Nation, and state functions
- Revised payment methodologies and financing of duties
- Efficient workflows between local and state functions
- Service continuity for people seeking and receiving long-term services and supports
- Methods for gathering public feedback and providing public awareness

A final report is due to the legislature by September 1, 2027.

- **Bill Reference:** CCRSF4476, Article 9, Section 57

## EAA for Homes and Vehicles

By October 1, 2026, the commissioner of human services must submit to the Centers for Medicare and Medicaid Services waiver plan amendments for the brain injury, community access for disability inclusion, community alternative care, and developmental disabilities 1915(c) waivers to implement the following reforms to environmental accessibility adaptations for homes and vehicles:

- Separate the treatment of home modifications from the treatment of vehicle modifications;
- Replace the existing \$40,000 annual limit for home modifications with a \$40,000 three-year limit
- Replace the existing provisions that permit a two-year limit of \$80,000 to be authorized during a two-year period with provisions permitting a six-year limit of \$80,000 to be authorized in a five-year period
- Limit permissible authorizations for home modification to only modifications meeting an assessed need that cannot be met in a less costly way in the person's current home
- Limit the number of similar or duplicative home modifications to modifications that are necessary for the health and safety of the person
- Establish caps on the number, size, and cost of common home modifications
- Replace the existing \$40,000 annual limit for vehicle modifications with a \$40,000 five-year limit
- Permit multiple authorizations for vehicle modifications in a five-year period when a vehicle is sold, provided that subsequent authorizations are limited to
  - » For a purchased adapted vehicle, the portion of the original purchase cost attributable to the vehicle modifications minus the book value of the purchase price attributable to the vehicle modifications; or for vehicle modifications, the original purchase and installation cost of the modifications minus the book value of the modifications

- **Bill Reference:** CCRSF4476, Article 9, Sections 58 and 59

## Access Rule

The commissioner of human services must 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 medical assistance home and community-based services

The initial phase of implementation efforts for home and community-based services must include:

- ↳ Updating critical incident oversight by implementing a system to track trends, resolution of incidents, and other information to enhance protections and improve outcomes for recipients
  - ↳ Establishing a home and community-based services grievance procedure and work unit to accept, investigate, and resolve grievances for home and community-based service recipients related to service providers, lead agencies, and the department
  - ↳ Establishing an advisory body for interested parties to advise on services, including direct care workers, beneficiaries, authorized representatives, and other individuals impacted by service rates
  - ↳ Establishing an advisory body for current and former beneficiaries, family members, and caregivers to advise the commissioner on policy and program administration
  - ↳ Publishing all medical assistance fee-for-service fee schedule payment rates
  - ↳ Developing and reporting on home and community-based service program integrity and quality measures to demonstrate state outcomes on wait list times; access to certain services, including the average time from eligibility determination to service commencement; service utilization; and other quality metrics
- **Effective Date:** The date following enactment
  - **Bill Reference:** CCRSF4476, Article 9, Section 57

## Innovation Pool

The Home and Community-Based Services Innovation Pool is repealed effective July 1, 2026.

- **Bill Reference:** CCRSF4476, Article 9, Section 62

## Electronic Visit Verification

The list of services required to be compliant with electronic visit verification is expanded to include:

- ↳ Personal care assistance services
  - ↳ Community first services and supports
  - ↳ Home health services
  - ↳ Adult companion services
  - ↳ Adult day services
  - ↳ Adult rehabilitative mental health services
  - ↳ Assertive community treatment
  - ↳ Early intensive developmental and behavioral intervention
  - ↳ Integrated community supports
  - ↳ Nonemergency medical transportation services
  - ↳ Recovery peer support
  - ↳ HCBS reimbursed at an hourly or specified minute-based rate
  - ↳ Other medical supplies and equipment or home and community-based services that are required to be electronically verified by the 21st Century Cures Act, Public Law 114-255
- **Effective Date:** Awaiting formal guidance from the Department of Human Services
  - **Bill Reference:** CCRSF4476, Article 10, Section 4

# PART TWO

## Human Services Omnibus Policy Bill

### Annual Training, 90-Day Window

A license holder must provide annual training to direct support staff on the topics identified in subdivision 4, clauses (3) to (11). A license holder may delay annual training up to 90 calendar days following the date by which the direct care staff would otherwise be required to receive the annual training.

- **Effective Date:** August 1, 2026
- **Bill Reference:** SF 476, 4th Engrossment, Article 4, Section 8

### Positive Support Analyst Qualifications

Positive Support Analyst Qualifications have changed from the previous requirement of a board-certified behavior analyst to the new requirement of a licensed behavior analyst, as follows:

*...be a ~~board-certified~~ licensed behavior analyst or a board-certified assistant behavior analyst certified by the Behavior Analyst Certification Board, Incorporated...*

- **Effective Date:** The date following enactment
- **Bill Reference:** SF 476, 4th Engrossment, Article 4, Section 10

### Measurable Benchmarks Requirement

Removes measurable benchmarks requirements for counties to improve efficiencies in the MnCHOICES program. Deletes the following language:

*(2) develop a set of measurable benchmarks sufficient to demonstrate quarterly improvement in the average time per assessment and other mutually agreed upon measures of increasing efficiency.*

*(c) The commissioner shall collect data on the benchmarks developed under paragraph (b) and provide to the lead agencies an annual trend analysis of the data in order to demonstrate the commissioner's compliance with the requirements of this subdivision*

- **Effective Date:** The date following enactment
- **Bill Reference:** SF 476, 4th Engrossment, Article 4, Section 17

## Informed Choice Policy

Establishes an informed choice policy, which states:

*Informed choice policy. (a) It is the policy of this state that all adults who have disabilities and, with support from their families or legal representatives, that all children who have disabilities:*

- ↳ *May make informed choices to select and utilize disability services and supports; and*
- ↳ *Are offered an informed decision-making process sufficient to make informed choices*

*It is the policy of this state that disability waivers services support the presumption that adults who have disabilities and, with support from their families or legal representatives, all children who have disabilities may make informed choices; and that all adults who have disabilities and all families of children who have disabilities and are accessing waiver services under sections 256B.092 and 256B.49 are provided an informed decision-making process that satisfies the requirements of subdivision 3a.*

*Lead agencies must support individuals in making informed choices by:*

- ↳ *Providing complete and accurate information about available home and community-based services and settings;*
- ↳ *Providing the information in a manner that is culturally and linguistically appropriate; and*
- ↳ *Facilitating access to services that reflect the individual's preferences and assessed needs*

*For individuals who are members of or affiliated with a federally recognized Tribal Nation located within Minnesota, informed choice includes the right to receive services administered or provided by the individual's Tribal Nation. Lead agencies must:*

- ↳ *Inform individuals of services offered by Tribal Nations enrolled as Minnesota health care providers;*
- ↳ *Directly coordinate with the individual's Tribal Nation human services agency when the individual seeks or may be eligible for services administered or provided by that Tribal Nation; and*
- ↳ *Ensure that service planning and delivery respects the individual's rights as both a member of a sovereign Tribal Nation and a resident of Minnesota.*

*County lead agencies and Tribal Nation human services agencies must establish and maintain procedures to share updated contact information, coordinate case management, and provide timely referrals necessary to ensure that informed choice is fully exercised.*

*Nothing in this section limits the sovereignty of Tribal Nations or the authority of Tribal governments to administer home and community-based services to their members.*

- **Effective Date:** The date following enactment
- **Bill Reference:** SF 476, 4th Engrossment, Article 4, Section 27

## Cost Reporting Changes

The commissioner shall conduct a random validation of data submitted under paragraph (a) of the statute to ensure data accuracy. Providers selected to validate cost reports must respond to the commissioner within 30 days with the requested financial documentation. If a provider fails to respond to the commissioner with all the requested information within 30 days, the commissioner must temporarily suspend payments. The commissioner must resume payments once the requested documentation is received. If a provider is unable to validate the provider's costs with supporting documentation, the commissioner must require the provider to participate in the random validation the next year that the commissioner selects providers to report their costs. The commissioner shall analyze cost documentation in paragraph (a) and provide recommendations for adjustments to cost components.

- **Effective Date:** January 1, 2027
- **Bill Reference:** SF 476, 4th Engrossment, Article 4, Section 28

## Service Suspension Changes

Adds new language to the service suspension statute:

*The program has not been paid for services, except an interruption to the person's public benefits that has lasted less than 60 days does not constitute nonpayment.*

- **Effective Date:** August 1, 2026
- **Bill Reference:** SF 476, 4th Engrossment, Article 8, Section 2

## Service Termination Changes

Adds new language to the service termination statute:

*The license holder has not been paid for services, except an interruption to a person's public benefits that has lasted less than 60 days does not constitute nonpayment;*

- **Effective Date:** August 1, 2026
- **Bill Reference:** SF 476, 4th Engrossment, Article 8, Section 3

## Community Living Settings

Individuals receiving services under a home and community-based waiver under section 256B.092 or 256B.49 may receive services in community-living settings. Community-living settings must meet the requirements of subdivision 2, paragraph (a), clause (1).

For the purposes of this section, direct financial interest exists if payment passes between the license holder or any controlling individual of a licensed program and the service recipient or an entity acting on the service recipient's behalf for the purpose of obtaining or maintaining a dwelling. For the purposes of this section, indirect financial interest exists if the license holder or any controlling individual of a licensed program has an ownership or investment interest in the entity that owns,

*continued*

## *Community Living Settings, continued*

operates, leases, or otherwise receives payment from the service recipient or an entity acting on the service recipient's behalf for the purpose of obtaining or maintaining a dwelling. Neither a direct nor an indirect financial interest exists if the service recipient is receiving services from a license holder or a licensed program that is not the license holder or a licensed program that owns, operates, leases, or has a direct or indirect financial interest in the setting in which the service recipient's services are being delivered.

- **Effective Date:** August 1, 2026
- **Bill Reference:** SF 476, 4th Engrossment, Article 8, Section 5

## **Medicaid Waiver Public Comment**

The commissioner shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over medical assistance at least 30 days before submitting a new Medicaid waiver request to the federal government.

Prior to submitting any Medicaid waiver request or Medicaid state plan amendment to the federal government for approval, the commissioner shall publish the text of the waiver request or state plan amendment, and a summary of and explanation of the need for the request, on the agency's website and provide a 30-day public comment period. The commissioner shall notify the public of the availability of this information through the agency's electronic subscription service. The commissioner shall publish the text of all public comments on the agency's website and consider public comments when preparing the final waiver request or state plan amendment that is to be submitted to the federal government for approval.

- **Effective Date:** The date following enactment
- **Bill Reference:** SF 476, 4th Engrossment, Article 9, Section 3

## **Medicaid Waiver and State Plan Amendments**

Medicaid waiver requests and state plan amendments; prohibited actions. Without prior legislative authorization under subdivision 24b, the commissioner must not take the following actions:

- ↳ Terminate a medical assistance program, waiver, or benefit; or
  - ↳ Request federal assistance with terminating a medical assistance program, waiver, or benefit
- **Effective Date:** August 1, 2026
  - **Bill Reference:** CCRSF4476, Article 10, Section 4

## Medicaid Waiver and State Plan Amendments, Legislative Authorization

States that:

*The commissioner must notify the chairs and ranking minority members of the standing committees of the house of representatives and senate with jurisdiction over medical assistance policy and finance at least 60 days prior to taking one of the actions listed under subdivision 24a.*

*Upon notification, the standing committees of the house of representatives and senate with jurisdiction over medical assistance policy and finance must schedule a hearing on the proposed action within 30 days of notification.*

*If all of the standing committees of the house of representatives and senate with jurisdiction over medical assistance policy and finance vote to advise the commissioner that a proposed action should not be implemented as proposed, the commissioner must not implement the proposed action until the legislature adjourns the annual legislative session that began after the vote of the committees. A committee vote under this subdivision must be by a majority of the committee.*

- **Effective Date:** August 1, 2026
- **Bill Reference:** SF 476, 4th Engrossment, Article 9, Section 5

## Unredacted Initial Optum Report

States that:

*For purposes of this section, “initial Optum reports” means the reports produced by Optum, Inc., under contract with the Department of Human Services and announced in the news release from the department on February 6, 2026.*

*Notwithstanding any law to the contrary, upon a joint request by the chairs and ranking minority members of a legislative committee with jurisdiction over human services policy and finance, the commissioner of human services must immediately release the initial Optum reports to the members of that legislative committee in the reports’ entirety without redactions or edits, except for redactions requested by Optum to protect proprietary information. Legislators or legislative staff who receive initial Optum reports under this section must not disseminate or publicize any not public data, as defined in Minnesota Statutes, section 13.02, subdivision 8a, that the reports contain.*

- **Effective Date:** 14 days following final enactment
- **Bill Reference:** SF 476, 4th Engrossment, Article 9, Section 9

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