DEPARTMENT OF HUMAN SERVICES

Minnesota Department of Human Services

2026 Supplemental Budget Book

Contents

Department of Human Services
FY 2026-27 Biennial Budget Change Item

Change Item Title: Transforming the Human Services System (OP-50)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	16,528	27,862	26,706
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	16,528	27,862	26,706
FTEs	**0**	**100**	**224**	**276**

Request:
The Governor recommends transforming administration of the human services system to improve the system for people accessing support. This proposal provides strategies that would streamline program administration, provide single oversight and control over program policies and procedures, and ensure consistency and access to care across the state.

This proposal:

- Eliminates the use of Managed Care Organizations (MCOs) in the Medicaid program
- Shifts administration of some financial eligibility functions from the counties to the State
- Dedicates funding for a study to provide future recommendations on the remaining financial eligibility functions at counties and Tribal Nations
- Addresses MnCHOICES long-term care assessment backlogs, increases oversight, and supports long-term solutions
- Reforms Waiver Case Management delivered by counties and Tribal Nations by phasing out the use of contracted case management and identifying roles, responsibilities, and service rates
- Dedicates funding for a study to provide future recommendations on county, Tribal, and state roles and responsibilities in administering human services programs

Rationale/Background:
The work of the Department of Human Services can be traced back to the mid 1800's when the State's first institutions were established. Soon thereafter, in 1883, the State Board of Correction and Charities was established, which eventually became the Department of Public Welfare in 1953, and then the Department of Human Services in 1983. Over the past 170 years, the system has evolved from almost exclusively serving people in large, undignified institutions to serving people in their homes and communities. Today, we strive to uphold a system that honors people's preferences and autonomy, regardless of their health, ability, or socioeconomic status. The journey to get here has been hard-fought and winding.

The foundation of the human services system has endured repeated Medicaid disinvestments, antiquated and overlooked technology infrastructure, the addition of innovative service models, shifts to privatization,

sophisticated program integrity threats, workforce pressures, and unfunded mandates from the federal government. To complicate matters more, Minnesota is one of 10 states that has a state-supervised, county administered human services system. It's becoming increasingly challenging for counties to meet the demands being placed on them. The culmination of these factors has led to a fragmented and wobbly foundation. To support better outcomes for people and the communities that serve them, a fresh look is needed.

Recognizing the long history of advancements and setbacks, this proposal would chart the first leg of a new journey to transform the human services system.

Decentralization of Duties in Minnesota's Human Services System
Today, Minnesota's health and human services programs are administered by the Minnesota Department of Human Services in collaboration with counties, Tribal Nations, and Managed Care Organizations. The decentralization of duties across multiple entities has occurred over multiple decades, while the complexity and growth of the programs has grown significantly over time.

State-Supervised, County-Administered Human Services
As one of the few states with a state-supervised, county-administered human services system, Minnesota counties are responsible for administering many aspects of the Medicaid program, such as financial eligibility, functional eligibility for long term care programs, case management, and care planning for people accessing long-term care services. Counties are also responsible for administering other human services programs, such as housing, behavioral health, economic assistance, licensing and oversight functions, and programs serving children and families. Currently, counties and Tribes incur significant costs in administering programs, experience large and growing caseloads, and face challenges in carrying out dynamic and changing complex program rules in human services administration.

Minnesota's 11 federally recognized Tribal Nations are recognized as sovereign. Several tribes act as lead agencies to conduct their own assessment and eligibility activities. As dual citizens, tribal members can choose to have their assessment and care coordination managed by their tribe or by the county/managed care organization. To honor Tribal sovereignty and respect the inherent authority of tribes to self-govern, Minnesota's Tribal Nations will determine if they will opt-in to the changes in this proposal. Ongoing collaboration and input is needed from Tribal Nations as the transformation journey continues.

Managed Care Organizations in Minnesota's Medicaid Program
Approximately 45% of Minnesota's Medical Assistance program spending, and 80% of basic care, is administered through Managed Care Organizations where the state contracts with a health plan, pays a set monthly capitation payment for each enrolled member, and the Managed Care Organization administers and pays the health care claims. Managed Care Organizations are contractually responsible for administering controls.

Currently, Minnesota State law requires that most of the members enrolled in Medical Assistance are served by managed care organizations. DHS currently contracts with 8 MCOs, 3 of which are County Based Purchasers (CBPs) to provide care to members.

Traditional benefits of using managed care include predictable budgeting, shared financial risk, and improved care coordination. However, in recent years, the state has experienced unpredictable budgeting, limited transparency in cost growth, and the financial risk has fallen on the Medicaid agency. The use of managed care also complicates navigation of the health care system for enrollees, their families, providers, and lead agencies. Managed care organizations set their own policies and procedures, such as restrictive network coverage, different prior authorization and utilization management processes, and different rate setting methods. This results in disparate access to care, limited transparency, and increased complexity for enrollees. Lastly, managed care plans are contractually required to conduct program integrity controls, however those controls vary by plan and lack

transparency across the system. Utilizing an MCO model in Medicaid presents more risk by not having centralized program integrity functions across the whole program.

Centralizing Program Administration

Decentralization of program administration has allowed for local connection and care coordination for enrollees. However, it also results in large caseloads and manual work for local governments, delays in eligibility determinations, and inconsistent and complex policies hindering access to care. It also makes it challenging to administer statewide program integrity controls and provide oversight over cost growth. This proposal provides strategies to transform the administration of the human services that would maintain functions at that the local level that provide value to the system and service recipients, while centralizing other functions to streamline, provide adequate controls, and ensure consistency and access to care across the state.

Proposal:

Eliminate the use of Managed Care Organizations (MCOs) in the Medicaid program

This proposal transitions the Medicaid program to be administered by a single, statewide Administrative Service Organization (ASO) rather than through multiple MCOs. Under a statewide ASO model, DHS would conduct a competitive request for proposals (RFP) to establish a single, statewide ASO that would perform administrative services on behalf of and overseen by DHS. The ASO would perform administration of claims, services, and other functions that are currently performed by Managed Care Organizations (MCOs) and county-based purchasers (CBPs) for both the current managed care and fee-for-service (FFS) populations. The ASO would be responsible for all service delivery and would be allowed to subcontract with additional, specialized entities (e.g., outpatient prescription drugs, NEMT, etc.).

A statewide ASO would serve as Minnesota's Medicaid fiscal agent by managing financial transactions, claims processing, and providing some services for state Medicaid agencies. These agents operate a modernized claims payment system to ensure compliance with federal regulations and process provider payments. Key roles include managing claims, provider inquiries, and sometimes supporting beneficiary self-direction programs. Overall, the statewide ASO would process and pay claims to providers enrolled in the Medicaid program through an enhanced claims processing system.

Under this proposal, DHS would retain all responsibility to design policy related to service delivery by the ASO and would require the ASO to follow these policies within the contract. DHS would retain responsibility to develop rates, prior authorization and utilization management policies, as well as other fraud, waste, and abuse oversight measures. All Medicaid enrollees would have access to the same network. To support ensuring positive health outcomes for the Medicaid population, DHS would undertake additional work to establish quality measures that incentivize value-based purchasing, implement high quality care coordination and other initiatives to drive value for the member and state.

This proposal assumes that Minnesota's current Basic Health Program, MinnesotaCare, would continue with managed care as required in federal regulations.

This proposal will result in Medicaid service rates currently paid under managed care organizations shifting to statewide rate methodologies paid under the fee-for-service model starting in January 2029. This proposal includes a contingent base appropriation of $8.9 million per year starting in FY2029 to be reinvested into rate increases by the legislature in future legislative sessions.

Shifting Medicaid Financial Eligibility Determinations to DHS

One key role that the county currently has is to establish eligibility for the Medicaid program. Eligibility rules and processes for all enrollees should not vary based on geographic location. This proposal provides a two-step approach to transition this function to the state. The first step transitions eligibility processing for some special

programs and manual eligibility functions to centralized state administration by July 1, 2028. The second step establishes an assessment and implementation workplan for the full transfer of Medical Assistance eligibility functions currently performed by County and Tribal Governments eligibility workers to DHS by December 31, 2032.

State Administered Processing for Special Programs and Manual Eligibility Functions

DHS will begin the transition to state administered eligibility processing by transferring the following eligibility functions from County and Tribal Governments to DHS by July 1, 2028:

- Data entry of all paper applications and completion of the eligibility determination for Medical Assistance for families with children, adults without children, and MinnesotaCare. If determined eligible for Medical Assistance, the case will be transferred to the County or Tribal Government for ongoing case maintenance.

- All eligibility functions related to MA for People with Breast or Cervical Cancer (MA-BC) including presumptive eligibility, application and renewal processing, ongoing case maintenance and client support.

- All eligibility functions related to Medical Assistance for children receiving Northstar adoption assistance including application processing, ongoing case maintenance and client support.

- Application processing for all Emergency Medical Assistance (EMA). If determined eligible the case will be transferred to the County or Tribal Government for ongoing case maintenance.

- Redetermining Medical Assistance eligibility for enrollees who are parents or adults without children and who turn 65 and become newly eligible for Medicare. Depending on outcome the case may be transferred to the County or Tribal Government for ongoing case maintenance; and

- Conducting ex parte renewals for Medical Assistance enrollees who are 65 or older, blind or have a disability.

This approach will initiate the first steps in the full transition of eligibility processing to the state, ease some of the administrative burden County and Tribal governments experience from manual eligibility processing and create centralized processing systems to prepare the state to assume the entirety of eligibility processing work by the implementation date. State administration of these functions will begin by July 1, 2028.

In order to centralize the processing of these eligibility functions, DHS must implement an electronic document management system (EDMS) that can interface with County and Tribal systems. The EDMS will act as a central storage solution for enrollee documents that can be accessed by appropriate users including enrollees and the necessary county, Tribal Nation, and state employees. This will create a more seamless enrollee experience and remove the burden of users currently experience providing the same documents in multiple places.

Currently, all mailed eligibility notices list the servicing agency (i.e., County or Tribal government agency) as the return address. Enrollees are instructed to return their completed forms to the servicing agency listed on their notice. The lack of a centralized return address prevents DHS from providing clear and simple messaging to applicants/enrollees, and limits DHS' ability to identify agency backlogs and monitor agency capacity to process work timely. In addition, a large amount of mail is returned by the post office each month due to an incorrect address. This returned mail adds additional burden to agencies and takes focus away from other case management work. A centralized mail solution will alleviate administrative burden and provide consistency in enrollees' experiences across the state. An EDMS system that interfaces with County and Tribal governments and

a centralized mail process are key functions to support the transition of remaining eligibility functions to state administrative processing.

In 2025, over 70,000 paper applications were submitted for Medical Assistance eligibility, comprising 30% of Minnesota Eligibility Technology System (METS) applications. Currently, paper applications are sent to the applicant's County or Tribal processing agency and stored within their document management system. The eligibility worker manually enters the information from the paper application into METS. Under this proposal, paper applications will be sent to DHS for processing. DHS eligibility workers will enter the information into METS, process the application through eligibility determination, and transfer the case to the County or Tribal processing agency for ongoing case management. Centralizing the METS application process will enable DHS to develop new processes and systems that better position the agency for the eventual transition to DHS processing all Medical Assistance eligibility determinations. It also decreases a source of time-consuming manual work from County and Tribal eligibility workers.

DHS will also assume all eligibility functions for MA-BC and Medical Assistance for children receiving Northstar adoption assistance. These programs both have unique eligibility criteria. By centralizing the administration of these programs, DHS will establish specialized units that provide application processing, ongoing case maintenance and client support. It will also reduce the number of specialized MA programs that County and Tribal governments are currently responsible for administering.

Under this proposal, DHS will also assume application processing for the eligibility components of Emergency Medical Assistance (EMA). If determined eligible the case will be transferred to the County or Tribal Government for ongoing case maintenance.

Finally, DHS will assume the administrative work to conduct Medical Assistance ex parte renewals for enrollees who are 65 or older, blind or have a disability whose eligibility is processed in the MAXIS system. Federal regulation requires that states attempt to redetermine Medical Assistance eligibility using reliable data sources already available to the agency without contacting the enrollee. The MAXIS system has not been programmed to conduct the ex parte process without manual worker intervention. This process is administratively burdensome and creates additional complexities for County and Tribal eligibility workers. DHS proposes to assume this process, which impacts over 12,000 cases each month relieving County and Tribal process agencies of this work.

For all these functions, to maintain tribal sovereignty, Tribal Nations who currently conduct these functions will have option to opt out of transferring these functions to the state.

Assessment and Implementation Plan for Remaining Medicaid Eligibility Functions

The second step is to procure a contract with a vendor to assess the current state and plan for the transfer of eligibility functions of the Medical Assistance program performed by County and Tribal Governments to the Minnesota Department of Human Services (DHS). DHS recommends that a report, in consultation with County and Tribal partners, should be prepared by October 1, 2028, and include comprehensive options, policy decisions and implications, and recommendations for Medicaid eligibility functions to be transitioned to DHS. The report will identify a process for a three-year implementation, which allows state assumptions to consider transition activities beginning by July 1, 2029, and full implementation be effective December 31, 2032.

This report will consider four main categories of work: (1) a comprehensive assessment of Medicaid eligibility functions performed by Counties and Tribal governments, including identification of handoffs between County/Tribal eligibility workers and state eligibility workers, as well as a catalog of eligibility functions performed by state eligibility workers (2) examine current expenditures, administrative budgets, and federal financial participation from County and Tribal administrative work related to Medicaid eligibility activities, (3) review, map and recommend updates to eligibility systems, and (4) establish recommendations for a successful transition of

centralized eligibility functions based on consultation with stakeholders, review of information provided by County and Tribal governments, and review of other states' best practices that maximizes federal dollars, outlines a feasible timeline of activities, and identifies required legislative changes and actions.

MnCHOICES Support Teams within the Department of Human Services

Counties, lead agencies, and Tribes currently have the responsibility to conduct assessments that determine an individual's program and service eligibility. This critical step is necessary for people to begin accessing waiver services and supports; however, delays often exist due to backlogs and resource constraints in completing these assessments. The Governor proposes creating a team of MnCHOICES certified assessors to assist counties, lead agencies, or Tribes to address these backlogs in assessment requests and conduct oversight and evaluation to determine long-term solutions to this challenge.

The proposal funds the creation of a statewide MnCHOICES certified assessors team (MnCHOICES Regional Support Division) within the Department of Human Services to assist counties, Tribes, and lead agencies with backlogs and establish prioritization criteria, including a team for cases that result in service eligibility without case management, or where MA eligibility is pending.

This proposal also provides administrative resources for a MnCHOICES Oversight & Evaluation Team that will work at an administration-level to determine complicating factors in the assessment and service authorization processes at the county/Tribe/lead agency level and evaluate streamlining efforts to inform future policy and system transformation, including:

- *MnCHOICES Statewide Certified Assessors Teams* – Purpose is to assist counties, Tribes, and lead agencies with assessment backlogs based upon criteria developed by MnCHOICES Oversight & Evaluation Team.
- *MnCHOICES Regional Support Team* – Supports cases where MA is pending or encountering system barriers, or where assessments result in programs without case management, such as State Plan Home Care services.
- *MnCHOICES Oversight & Evaluation Team* – Tracking lead agency waitlists, developing MnCHOICES state assessor prioritization guidelines and policy criteria, and research and evaluation into impact of statewide MnCHOICES accessors on waitlists, enrollment, and utilization of LTC programs. Team will work at an administration-level to determine complicating factors in the assessment and service authorization processes at the county/Tribe/lead agency level and contribute to future streamlining efforts.

Reforming Waiver Case Management

Waiver case managers and care coordinators are responsible for developing a person's support plan and ensuring that services authorized by the county or Tribal Nation meets the person's needs. Case management is a critical service for Minnesotans with disabilities and older adults. However, case management has not been structurally updated in more than a decade.

Current challenges include:

- Inconsistent rates across waiver programs, creating inequities.
- Unsustainable caseloads for case managers and high workforce turnover.
- Lack of defined roles and responsibilities.
- Fragmented statutory requirements scattered across multiple statutes.
- Inconsistent oversight and expectations for contracted case management agencies

All of these challenges present risks in terms of a person's experience in accessing services that meet their needs as well as program integrity in the human services system, as case management is a critical role in ensuring that a person receives services and supports that meet their needs and are in their service plan.

Phasing Out the Use of Contracted Waiver Case Management
Currently, many counties and managed care organizations utilize contracted case management, resulting in varying enrollee experience as well as inconsistent oversight and expectations of contracted case management agencies. This proposal requires the phase out of contracted case management by July 1, 2031.

Waiver Case Management Study for Future Reform
Waiver case managers are responsible for developing a person's support plan and ensuring that services authorized meet their needs. A comprehensive study of the requirements and costs of case management services is necessary to ensure effective oversight, appropriate funding, and the provision of high-quality services to the residents of Minnesota.

This proposal provides one-time funding to study and recommend:

- Roles and responsibilities for case management services, including oversight functions
- Requirements of case management services
- Rate methodology that reflects the costs of providing case management services
- Assessment in recommending case management in acute care settings to ensure continuity of care

The study will cover case management services provided under all relevant Minnesota Statute sections and rules. This study will provide recommendations to the legislature by June 30, 2027.

<u>Statewide Assessment of the Roles and Responsibilities of Counties and Tribal Nations in Administering Human Services Programs</u>
Lastly, this proposal would require a comprehensive study on the remaining role of counties and Tribal Nations in administering human services programs and would recommend changes to the legislature in the 2029 legislative session.

Study of Department of Human Services (DHS) Programs
The scope of this study would include all programs and functions administered by the Department of Human Services, including Medicaid, MinnesotaCare, behavioral health services, housing and homelessness, Minnesota Supplemental Aide, General Assistance, and licensing and oversight functions.

This study would:

- Identify and assess the current roles and responsibilities held by counties and Tribal Nations
- Assess the challenges and benefits of these roles, through the lens of people accessing services, families, advocates, counties, Tribes, providers, and state staff
- Assess how other states administer their Medicaid programs, focusing on the roles and responsibilities of the local governments versus the state Medicaid or human services agency.
- Assess the financing of human services administration across the state agency, counties, and tribal nations
- Identify recommendations for what the ideal delegation of duties should be with the goal of having a transparent, accessible, accountable, equitable, and effective system for all parties.
- Recommend financing strategies and estimate the state fiscal impact of recommended functions moving to the state.

Study of Department of Children, Youth, and Families (DCYF) Programs
Counties and Tribal Nations also administer many functions related to human services programs serving children, youth, and families. This study will also conduct a statewide assessment of state and county roles for

administering provider licensing functions, the Fraud Prevention Investigation functions, economic assistance programs, and the Child Care Assistance Program. The study will:

- Identify and assess the current roles and responsibilities held by counties and the State for oversight and administration of these functions
- Evaluate impacts on efficiencies, effectiveness, and outcomes associated with county-administered and state-administered models
- Estimate current costs for county administered functions and the fiscal impact of moving to a state-administered system
- Analyze current financing models and resources that support county-administered human services and the impact of shifting them to support a state administered model
- Assess policy, legal, operational, IT, human resource, and other changes needed to shift county administered functions to the state

Fiscal Impact

Below is the net fiscal impact for each component in this proposal:

Component	FY26	FY27	FY26/27	FY28	FY29	FY28/29
ASO Model	-	798	798	538	(538)	-
State Administered Eligibility Processing & Study	-	7,678	7,678	18,064	18,060	36,124
MnCHOICES Assessment Team, Workgroup, & Study	-	2,538	2,538	6,751	6,362	13,113
Waiver Case Management Study	-	204	204	-	-	-
Prohibition on Contracted Waiver Case Management	-	-	-	-	-	-
County/State Role Study & Proposal-Wide Project Management	-	2,477	2,477	518	518	1,036
Proposal-Wide Central Office Resources	-	587	587	1,343	1,656	2,999
DCYF Study (DCYF Resources)	-	2,246	2,246	648	648	1,296
Total	-	16,528	16,528	27,862	26,706	54,569

Below is the total fiscal impact of this proposal:

Department of Human Services

Net Impact by Fund (dollars in thousands)			FY 26	FY 27	FY 26-27	FY 28	FY 29	FY 28-29
General Fund			-	14,282	14,282	27,214	26,058	53,272
HCAF			-	-	-	-	-	-
Federal TANF			-	-	-	-	-	-
Other Fund			-	-	-	-	-	-
Total All Funds			-	14,282	14,282	27,214	26,058	53,272
Fund	**BACT#**	**Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	11	OPS FTEs for study and proposal wide project management (0, 4, 4,4)	-	643	643	762	762	1,524
GF	REV1	Admin FFP @ 32%	-	(206)	(206)	(244)	(244)	(488)
GF	11	One-time funds for statewide study	-	3,000	3,000	-	-	-
GF	REV1	Admin FFP @ 32%	-	(960)	(960)	-	-	-
GF	14	Vendor Contract- Waiver Case Management	-	300	300	-	-	-
GF	REV1	Admin FFP @ 32% - Waiver Case Mgmt	-	(96)	(96)	-	-	-
GF	14	Contract Admin (MnCHOICES Workgroup and Final Report)	-	450	450	500	250	750
GF	REV1	Admin FFP @32%	-	(144)	(144)	(160)	(80)	(240)
GF	14	MnCHOICES Assessment FTEs Support and Oversight Team (0,15, 50, 50)	-	2,515	2,515	9,258	8,726	17,984
GF	REV1	Admin FFP @32%	-	(805)	(805)	(2,963)	(2,792)	(5,755)
GF	14	Mileage Reimbursement	-	-	-	126	265	391
GF	REV1	Admin FFP @32%	-	-	-	(40)	(85)	(125)
GF	11	MnCHOICES Systems Changes	-	103	103	21	21	42
GF	11	MnCHOICES FEI Support Changes	-	30	30	9	57	66

GF	11	MnCHOICES (MCO Changes)	-	244	244	-	-	-
GF	11	MnCHOICES MCO Changes (MNIT)	-	145	145	-	-	-
GF	13	HCA Admin FTEs - (0, 79, 164, 164)	-	7,391	7,391	25,781	24,273	50,054
GF	11	Ops Admin FTEs - (0, 1, 2, 2)	-	111	111	360	342	702
GF	13	HCA Admin Software Updates and Mail Processing Hardware	-	-	-	-	467	467
GF	13	HCA Admin - EDMS System	-	-	-	-	1,053	1,053
GF	13	HCA Admin Contract - State Administered Eligibility Processing Assessment	-	2,000	2,000	-	-	-
GF	11	HCA MPPS FTE (State Share @29%) (0, 1, 1, 1)	-	30	30	50	50	100
GF	REV1	Admin FFP @32%	-	(3,041)	(3,041)	(8,365)	(8,363)	(16,728)
GF	11	MAXIS (State Share @55%)	-	244	244	49	49	98
GF	11	METS (State Share @ 38%	-	943	943	189	189	378
GF	33ED	MA Grants	-	-	-	-	(11,185)	11,185)
GF	33AD	MA Grants	-	-	-	-	25,349	25,349
GF	33FC	MA Grants	-	-	-	-	(34,504)	(34,504)
GF	33FC	MA Grants Contingent Appropriation	-	-	-	-	8,883	8,883
GF	13	HCA Admin (FTE 0, 0, 0, 52)	-	-	-	-	7,819	7,819
GF	11	FOD Admin (FTE 0, 0, 3, 3)	-	-	-	556	503	1,059
GF	13	HCA Care Coordination	-	-	-	-	7,000	7,000
GF	13	HCA P/T Contract	-	-	-	-	500	500
GF	REV1	Admin FFP @ 32%	-	-	-	(178)	(5,063)	(5,241)
GF	11	MMIS (State Share @ 29%)	-	798	798	160	160	320
GF	11	DHS Central Office	-	863	863	1,975	2,436	4,411
GF	REV1	Admin @32%	-	(276)	(276)	(632)	(780)	(1,412)
Fund	**BACT#**	**FTEs Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	11	MAPE 18L (OPS complex projects)	0	4		4	4	
GF	14	ADSA FTEs (0,15,50,50)	0	15		50	50	
GF	13	HCA FTEs	0	79		164	216	
GF	11	OPS FTEs - FOD	0	0		4	4	
GF	11	OPS FTEs - Communications	0	1		1	1	
GF	13	HCA FTEs - MPPS	0	1		1	1	
			0	**100**		**224**	**276**	

Department of Children Youth and Families

Net Impact by Fund (dollars in thousands)			**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
General Fund			-	2,246	2,246	648	648	1,296
Federal TANF								
Other Fund								
Total All Funds			-	2,246	2,246	648	648	1,296
Fund	**BACT#**	**Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	11	Staff (0,5,5,5)	-	804	804	953	953	1,906
GF	11	Vendor to analyze DCYF scope	-	2,500	2,500	-	-	-
GF	REV1	FFP @ 32%	-	(1,057)	(1,057)	(305)	(305)	(610)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
			0	5	5	5	5	5

Impact on Children and Families:

The intention of this proposal is to streamline administration of the human services program. Inconsistent policies and procedures across the Medicaid program result in disparate access to needed healthcare services and supports.

In any large systems transformation, transitioning functions and processes poses risk to people relying on supports during the transition. DHS will work with community partners, counties, and Tribes to help ensure

service continuity with a focus on maintaining and improving access to critical human services supports for children and families.

Equity and Inclusion:

The intention of this proposal is to streamline administration of the human services program. Inconsistent policies and procedures across the Medicaid program result in disparate access to needed healthcare services and supports. This proposal will help ensure that program policies and procedures are the same across the state, improving transparency and making it easier for people to navigate. As functions transition to a statewide model, DHS will prioritize equity and inclusion and seek community input to inform how the system is structured.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

This proposal will significantly impact Tribal Nations. As such, this proposal includes requirements for robust consultation with Tribal Nations on design and implementation of these changes, as well as the ability for Tribal Nations to opt out of transferring these duties until consultation with impacted Tribes can be fully conducted and there is agreement with each Tribal Nation.

Impacts to Counties:

This proposal will significantly impact counties. Counties have determined eligibility for Medical Assistance and long-term services and supports for decades and have built up systems around those responsibilities. This proposal will significantly impact county responsibilities, staffing resources, and computer systems. DHS will work with counties and Tribal Nations as functions transfer to mitigate unforeseen impacts and to ensure a smooth transition for enrollees.

IT Costs

This proposal requires systems changes as follows:

- Eliminating MCOs and shifting to an ASO model will require changes to the MMIS system.
- Shifting some Medicaid eligibility functions to the State will require changes to MAXIS and METS.
- MnCHOICES assessments conducted at the state will require MnCHOICES systems changes.

Statutory Change(s):

This proposal will require changes to the following statutes:

- Sec. 256B.49 MN Statutes
- Sec. 256B.092 MN Statutes
- Sec. 256B.0625 MN Statutes Subd. 20a
- 9525 - MN Rules Chapter
- Sec. 256B.0625 MN Statutes Subd. 20b and 44
- Sec. 256B.0911 MN Statutes Subd. 11(ii-iii), Subd. 20(d), Subd. 25, Subd. 29-30
- Sec. 256B.4905 MN Statutes
- Sec. 256S.08 MN Statutes
- Sec. 256B.0913 MN Statutes
- Section 256B.0922 MN Statutes
- Section 256S MN Statutes

Department of Human Services
FY 2026-27 Biennial Budget Change Item

Change Item Title: Federal Compliance - Medical Assistance Eligibility Changes Due to H.R. 1 (HC-40)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	124	(18,959)	(17,504)
Revenues				
Other Funds				
Expenditures				
Revenues				
Net Fiscal Impact = (Expenditures – Revenues)	0	124	(18,959)	(17,504)
FTEs	**0**	**57.5**	**57.5**	**57.5**

Request:

The Governor recommends statutory changes and funding to comply with new Medicaid eligibility requirements from the 2025 federal budget reconciliation bill (H.R. 1, Public Law 119-21) signed into law.

The new federal Medicaid eligibility requirements included in this proposal are:

- Limiting retroactive Medicaid coverage
- Obtaining enrollee address information
- Six-month eligibility renewals for certain Medicaid enrollees
- Work requirements for certain Medicaid applicants and enrollees
- Legal noncitizen full Medicaid coverage restrictions

Rationale/Background:

On July 4, 2025, the federal budget reconciliation bill (H.R.1) was signed into law (Public Law 119-21) requiring states to make several changes to Medicaid programs. The new Medicaid eligibility requirements are detailed below with impacts to Minnesota's Medicaid program called Medical Assistance (MA).

<u>Limiting Retroactive Medicaid Coverage</u>

Currently, Medicaid applicants may qualify for up to three months of retroactive coverage prior to the month of application. Effective January 1, 2027, the new federal law provides fewer months of retroactive Medicaid coverage for applicants. Minnesota's MA applicants who are ages 21 to 64, do not have dependent children, are not pregnant and not seeking MA based on disability (also referred to as MA Adults without Children or the expansion group), may qualify for one month of retroactive coverage. All other MA applicants may qualify for up to two months of retroactive coverage.

<u>Obtaining Enrollee Address Information</u>

Effective January 1, 2027, states must use data from managed care plans, the United States Postal Service National Change of Address (NCOA) Database, returned mail, and other data sources identified by the Secretary of Health and Human Services (HHS) to regularly update Medicaid enrollee addresses. HHS also intends to establish a new national federal database by October 1, 2029, which will identify individuals simultaneously enrolled in Medicaid in more than one state.

<u>Six-Month Eligibility Renewals for Certain Medicaid Enrollees</u>

Currently, Medicaid enrollees are subject to annual eligibility renewals. Effective January 1, 2027, eligibility must be renewed every six months for Medicaid expansion enrollees, except for those who are American Indians or

Alaska Natives. Minnesota's MA enrollees who are ages 21 to 64, do not have dependent children, are not pregnant and not seeking MA based on disability (also referred to as MA Adults without Children or the expansion group), will be subject to six-month eligibility renewals starting January 1, 2027.

Work/Community Engagement Requirements for Certain Medicaid Applicants and Enrollees
Currently, there are no work or community engagement requirements for individuals to qualify for or to maintain Medicaid coverage. Effective January 1, 2027, States must condition Medicaid eligibility on compliance with work/community engagement requirements for applicants and enrollees in the Medicaid expansion group unless the individual meets one of many exemptions.

An individual is exempt from work/community engagement requirements if they are:

- an American Indian or Alaska Native,
- a family caregiver of a disabled individual,
- a veteran with a disability rated as total,
- medically frail, disabled or have special medical needs,
- already meeting similar requirements as a recipient of the Minnesota Family Investment Program or the Supplemental Nutrition Assistance Program, or
- participating in a drug addiction or alcohol treatment program, or
- Incarcerated.

Additionally, individuals are temporarily exempt from work/community engagement requirements if they are hospitalized, receiving nursing facility or similar services, residing in a county in which there is an emergency or disaster declared, residing in a county with a high unemployment rate, were recently incarcerated, or need to travel to get medical care for themselves or a dependent.

Minnesota MA applicants and enrollees who are ages 21 to 64, who do not have dependent children, are not pregnant and not seeking MA based on disability (also referred to as MA Adults without Children or the expansion group), will be subject to work/community engagement requirements if they do meet an exemption starting January 1, 2027.

Legal Noncitizen Full Medicaid Coverage Restrictions
Effective October 1, 2026, the new federal law limits full Medicaid coverage to people who are Lawful Permanent Residents (LPR), Cuban or Haitian entrants, and Compact of Free Association (COFA) migrants. This eliminates full Medicaid coverage for people with all other immigration statuses including refugees, asylees, certain abused spouses and children, trafficking victims, and others granted protection under a humanitarian basis. The new federal law does not change Emergency Medical Assistance eligibility and full Medicaid coverage is still available to lawfully present children and pregnant women under the Children's Health Insurance Program Reauthorization Act (CHIPRA) 214 option. In Minnesota, full MA coverage will no longer be available to non-pregnant adults whose immigration status is other than Lawful Permanent Resident, Cuban or Haitian entrant, or Compact of Free Association (COFA) migrant beginning October 1, 2026.

Proposal:

This proposal seeks state law changes and administrative funding necessary to comply with the new federal Medicaid eligibility requirements in Public Law 119-21 including legal noncitizen full MA coverage restrictions effective October 1, 2026, and these changes effective January 1, 2027: limiting retroactive MA coverage, obtaining enrollee address information, six-month eligibility renewals, and work/community engagement requirements for MA Adults without Children.

Fiscal Impact:

Programmatic Fiscal Impact
The changes in Public Law 119-21 are projected to change spending in MCHP as follows:

Limiting Retroactive Medicaid Coverage
Current state law specifies three months of retroactive coverage and the current state budget forecast assumes that with changes made by HR1, the incremental months of coverage beyond the new federal limits are paid for with all state funds. This proposal proposes to change state law to the federal coverage period limits. Changing state law to align with the new federal retroactive Medicaid coverage period will produce savings of $10,992,159 in FY2027 and $70,143,766 in FY2028-2029.

Obtaining Enrollee Address Information
There are no programmatic fiscal impacts associated with this provision.

Six-Month Eligibility Renewals for Certain Medicaid Enrollees
There are no programmatic fiscal impacts associated with this provision.

Work/Community Engagement Requirements for Certain Medicaid Applicants and Enrollees
Complying with the new work/community engagement requirement will produce savings of $1,101,275 FY2027 and $3,188,731 in FY2028-2029.

Legal Noncitizen Full Medicaid Coverage Restrictions
There are no programmatic fiscal impacts associated with this provision.

Administrative Fiscal Impact
Implementing and administering the MA eligibility changes in this proposal will require additional staff, vendor contracts, and other administrative costs across DHS, impacting several teams across the enterprise. The costs have been outlined below if attributable to specific provision changes, but several costs are associated with the administration of several changes and are outlined in general compliance sections below.

FTE Overview

Provision	Division	FTE Count and Level
Limiting Retroactive Medicaid	NA	0
Obtaining Enrollee Address Information	HCEO	1
	HRQ	1
Six-Month Eligibility Renewals for Certain Medicaid Enrollees	NA	0
Work Requirements for Certain Medicaid Applicants and Enrollees	SMRT	15
	HCEO	6
	HCEA	2
Legal Noncitizen Full Medicaid Coverage Restrictions	GCO	1
Appeals, Reporting, and General Compliance	HCIA	8
	Human Services Appeals and Regulations	8.5
	HRQ	2
	OMMD	5
	GCO	2
	FR	1
	PMO	4

	FOD	1

Administrative Cost Overview (total dollars)

Provision	Expense	Cost
Limiting Retroactive Medicaid	NA	$0
Obtaining Enrollee Address Information	National Change of Address (NCOA) contract	$1,000,000 per FY.
Six-Month Eligibility Renewals for Certain Medicaid Enrollees	Federal Data Services Hub	$12,491,716 in FY2028 and $14,940,572 in FY2029
	Navigator Incentive Payments	$250,000 in FY27, $500,000 each FY thereafter.
Work Requirements for Certain Medicaid Applicants and Enrollees	Non-Federal Hub Verification Costs	$1,000,000 per FY.
Legal Noncitizen Full Medicaid Coverage Restrictions	NA	$0
General Implementation and Communications of all Public Law 119-21 Eligibility Provisions	Required Outreach to Impacted Enrollees (texting)	$15,000 per FY.
	Required Outreach to Impacted Enrollees (mail and translations)	$110,000 in FY2027, and $52,000 each FY thereafter
	PMO Administrative Vendor Costs	$4,000,000 per FY.
Community Outreach	Minigrants	$1,250,000 in FY2027 and FY2028, and $625,000 in FY2029
	Contract for Community Conversations and Minigrant Recipient Meetings	$520,000 in FY2027 and FY2029, $20,000 in FY2028
	Three rounds of media production with culturally specific media partners, production and distribution of social media videos, and paid search and social	$375,000 in FY2027, $182,000 in FY2028, and $185,000 in FY2029
	TV and Radio distribution of key messages	$110,000 in FY2027, $115,000 in FY2028, and $125,000 in FY2029

Obtaining Enrollee Address Information

FTE Costs

The Health Care Eligibility Operations (HCEO) Division within the Health Care Administration (HCA) of DHS will require one MAPE 14L full time employee (FTE) on an ongoing basis to support with developing systems instructions that will be shared with eligibility workers and other business area stakeholders to ensure data from managed care plans, returned mail, the NCOA database and other data sources identified and deployed by HHS are utilized properly to update enrollee address information. This role will ensure that system design documents, procedures and tests are complete and ensure that post-deployment issues are resolved. This change will require work on a monthly basis going forward, and as such, this FTE will be an ongoing need.

The Health Care Research and Quality (HRQ) Division within HCA will require one MAPE 18L to develop initial and ongoing reporting to monitor, evaluate and report out progress on the enrollee address information obtained

through new methods implemented as a result of this change. This change will require work on a monthly basis going forward, and as such, this FTE will be an ongoing need.

Administrative Costs
DHS requires $1 million to establish a contract and license with the NCOA database and will use existing staffing resources to ensure enrollee address information is up to date. This cost will invest in address validation software DHS will host on-premise to ensure notices are reaching enrollees.

Six-Month Eligibility Renewals for Certain Medicaid Enrollees
FTE Costs
FTEs to support with implementing this provision are included in the General Implementation section below. It is anticipated that implementing this change will require additional capacity to update systems instructions and training with counties, as well as additional capacity to manage increasing and more complex appeals.

Administrative Costs
To facilitate six-month renewals on an ongoing basis, the Health Care Eligibility and Access Division (HCEA) within HCA requires funding to maintain a contract with the Federal Data Services Hub. This contract allows DHS to obtain data from various federal databases to electronically verify applicant and enrollee information including Social Security Numbers, citizenship, immigration status, income and other factors. This cost is $12,491,716 in FY2028 and $14,940,572 in FY2029.

Additionally, conducting two renewals a year for MA Adults without Children adds an opportunity for enrollees to seek assistance from Navigator agencies in completing their renewal forms. In reviewing previously underspent navigator incentive payment accounts, DHS anticipates that implementing six-month renewals will result in exceeding current navigator incentive payment amounts, requiring an additional $250,000 in FY2027 and $500,000 each FY thereafter.

Work/Community Engagement Requirements for Certain Medicaid Applicants and Enrollees
FTE Costs
It is anticipated that the new requirements will impact how many people seek disability determinations thorough the State Medical Review Team (SMRT). The SMRT Division within HCA requires 15 FTEs on an ongoing basis to support with increased SMRT referrals to assess disability statuses. These 15 FTEs include three MMA 18Ks, 2 MAPE 15Ls, 7 MAPE 11Ls, and 3 MAPE 8Ls. Two MMA 18Ks will serve as Disability Unit Supervisors. The influx of SMRT referrals anticipated upon implementation of this provision will create an increased and more complex workload that requires two new team leads, which can each manage up to 12 direct reports. One MMA 18K will serve as a SMRT Training Lead, which will be responsible for the training and development of new and existing staff and support quality assurance and internal auditing of disability determinations made by each disability analysts to be sure they are following correct statutes and issuing appropriate decisions. The two MAPE 15Ls will be Appeal Team Leads, who will be responsible for handling appeal briefings and hearings for SMRT denials and serve as the primary contact for lead case consults on complex cases. Seven MAPE 11Ls will serve as Disability analysts, who process SMRT referrals, complete review of medical evidence and apply disability law to issue fair and accurate disability decisions. Finally, 3 MAPE 8Ls will be County Liaisons helping process referrals, confirm documentation is accurate and support disability analysts.

The Health Care Eligibility and Access Division (HCEA) requires two MAPE 14Ls that will serve as subject matter experts in Medicaid work/community engagement requirements, responsible for analyzing, developing, organizing, implementing, supporting and maintaining eligibility policies. This includes translating federal regulations and guidance into rules and engaging with other agencies, states, counties and Tribal stakeholders in the ongoing maintenance and oversight of these requirements. Initial guidance from the Centers for Medicare & Medicaid Services (CMS) related to implementing work requirements is anticipated to be shared with states in the

summer of 2026. These positions will be integral to develop, launch and maintain the MA work/community engagement policies in Minnesota.

The HCEO Division requires 6 FTEs including one MAPE 14L and five AFSCME 66 roles. The MAPE 14L will support the training and maintaining of systems instructions across eligibility workers by ensuring that system design documents, procedures and tests are complete, reviewing final manual content and manage post-deployment periods to resolve system defects and project reports for eligibility workers. The five AFSCME 66 FTEs will be responsible for processing health care eligibility determinations and changes in circumstances, and answer enrollee questions regarding eligibility and covered services.

Administrative Costs
DHS also requires $1 million in FY2027 and each fiscal year thereafter to support establishing data sharing agreements with reliable resources to support verifying work requirements for impacted enrollees. For example, this funding could be used to contract with the Consent Based Verification Service (CBV) that is currently being developed by CMS. CBV will be a fee-based service that allows enrollees to give their consent online and to share their payroll information.

Legal Noncitizen Full Medicaid Coverage Restrictions
FTE Costs
DHS' General Compliance Office (GCO) requires one Staff Attorney 3 Level with a focus on immigration law to support with ongoing advice and compliance with this provision.

Increased and More Complex Appeals
FTE Costs
The Health Care Integrity and Accountability Division within HCA requires eight FTEs on an ongoing basis, including two MAPE 8L, four MAPE 11L, and two MMA 18K roles. Overall, these FTEs will support processing the increase of appeals as a result of disenrollments due to new work requirements and six-month renewals for the adults without children population. These appeals are managed within the METS system, which is overseen by DHS rather than county eligibility workers. It is expected that these appeals will also be more complicated in light of new federal eligibility requirements. The MAPE 8L positions will be responsible for reviewing incoming appeals and completing preliminary actions such as contacting service agencies to request case corrections, additional processing, and securing supporting documents. These roles also determine eligibility for continued benefits and end-stage tasks once an appeal is resolved, such as closing benefits. The MAPE 11L positions review and formally respond to enrollee appeals related to closed or changed eligibility, either due to incomplete renewal submissions or program changes following successful renewal processing. Finally, the MMA 18K positions will take on supervisory needs of teams, as supervisory roles can only oversee 15 non-supervisory staff, and respond to more complex case issues as well as address program integrity and team performance issues.

The Appeals team within the Chief Compliance Office of DHS requires 8.5 FTEs on an ongoing basis, including 1 Human Services Manager 2 17M, 5 MAPE 19Ls, 1 AFSCME 73J, 1 AFSME 65M, and a .5 AFSCME 61L. Overall, these FTEs will support processing the increase of appeals across the eligibility changes as a result of Public Law 119-21. These appeals staff are utilized to adjudicate appeals across the SMRT division as well as other populations' eligibility determinations. This individual reviews and issues final decisions in administrative hearings. The 1 Human Services Manager 2 will be a new Chief Judge that manages fair hearings so that administrative appeals are heard and decided in a timely manner that is consistent with state and federal laws, rules and regulations. The 5 MAPE 19L's will be Human Services Judges that are responsible for conducting administrative fair hearing, which includes reviewing evidence along with relevant state and federal laws to prepare an independent recommended order resolving the appeal. The 1 AFSCME 73J will be a paralegal that supports DHS in maintaining compliance with state and federal laws by providing advanced legal support to the Appeals Division through legal research, preparing case files and managing hearings. The 1 AFSME 65M will be a Legal secretary that will be responsible for

technical support for state fair hearings by include reviewing and docketing appeals, scheduling hearings, serving as a point of contact for parties and the public, resolving technical issues, and mentoring other staff on complex appeal processes. Finally, the .5 AFSME 61L will be a part time Customer Services Specialist that will support with responding to calls from staff and customers and maintain accurate data in the Appeals database to support efficient case tracking and performance measurement.

General Compliance, Reporting, and Communications

FTE Costs

The HRQ Division within HCA will require one MAPE 18L and one MAPE 14L. A MAPE 18L is required on an ongoing basis to help develop initial and ongoing reports in anticipation of ongoing, cyclical required reports and to be responsive to ad-hoc reports upon request. A MAPE 14L is required to develop, maintain and run periodic data reports and fulfill required and ad-hoc reports under the guidance of the MAPE 18L. Additional reports that CMS or the state legislature require and request need staff with significant analytical and programming experience, and detailed understanding of policy and business needs.

The Project Management Office (PMO) within DHS will require 4 FTEs, each classified as MAPE 17Ls. Two of the MAPE 17Ls will be responsible for project management, operation and execution support for the implementation workplan and support policy and operation workstreams. The remaining two MAPE 17Ls will oversee and manage vendors DHS has contracted with to support eligibility and enrollment implementation activities, serving as the primary point of contact for vendors and making sure responsibilities are being fulfilled by the vendor.

DHS' GCO requires two Staff Attorney Level 3 FTEs to advise on an ongoing basis for Public Law 119-21 implementation and ongoing compliance. Additionally, DHS' Federal Relations Team requires 1 MAPE 17L to support with coordinating ongoing review of CMS guidance and reporting.

DHS Finance Operations Division (FOD) requires 1 MAPE 18L Financial Analyst to analyze trends and impacts of changes related to Public Law 119-21 for counties and DHS, and service impacts on federal financial participation on retroactive changes related to Public Law 119-21.

Administrative Costs

To support implementation efforts, DHS' Project Management Office (PMO) requires $4,000,000 of administrative vendor costs on an ongoing basis to streamline and implement provisions of Public Law 119-21 in the most efficient manner possible. For example, this funding will be used to contract with vendors that enhance DHS' ability to cross reference the Death Index to ensure that deceased individuals do not remain enrolled in MA. As DHS awaits further guidance from CMS about provisions of Public Law 119-21, the PMO is developing a strategy to implement systems changes and new procedures efficiently and effectively and will also use this funding to support a streamlined approach to implementing other eligibility changes including work/community engagement requirements.

HCEO and MPPS also require $80,000 in FY27, and $20,000 each FY thereafter, for translation services, $15,000 each fiscal year for texting costs, and $30,000 in FY27 and $32,000 each FY thereafter for printing and postage to impacted enrollees from the legal noncitizen definition change, 6-month renewals and work requirement provisions. This funding will also support a 2027 cohort renewal stuffer for all renewal notices regarding Public Law 119-21 changes.

Community Outreach

FTE Costs

The Office of Medicaid Medical Director (OMMD) requires five FTEs on an ongoing basis including one MAPE 14L, two MAPE 17Ls, 1 MAPE 18L, and 1 MMA 21K. The MAPE 14L will be a Community Engagement and Communication Specialist that will be responsible for coordinating with DHS' communication team and external community partners to design, develop and track evaluation of the distribution of multi-lingual materials for

targeted audiences and manage other community engagement plans. The two MAPE 17Ls will serve as Community Engagement Specialists that will be responsible for direct outreach and engagement with local community partners and organizations statewide to develop and sustain events and educational sessions both virtually and in person. The MAPE 18L will serve as a Research Scientist that leads qualitative research and analysis to assess the impact and effectiveness of community engagement strategies, as well as develop tools and methods for collecting, analyzing and reporting community feedback and program data that will be circulated among communities and distributed in reports. The MMA 21K Supervisor will be responsible for guiding strategic outreach initiatives, supporting team development, and ensuring successful planning and execution of community engagement programs and partnerships.

Administrative Costs

OMMD requests $1,250,000 in FY27 and FY28 to facilitate a minigrant program offering $50,000 to 25 community and faith-based organizations conducting culturally specific and linguistically appropriate outreach and engagement. DHS worked with many organizations performing similar work during unwind efforts following the end of the public health emergency. The grant funding will be reduced to $25,000 for 25 organizations in FY29. To support with this effort, OMMD requires $20,000 per grant year to facilitate quarterly virtual collaborative meetings with grant recipients to share learnings and identify ongoing needs. OMMD also requests $500,000 in FY27 and FY29 to support facilitation of Medicaid enrollee User Feedback sessions to collect learnings and understand impacts of community messaging following the implementation of Public Law 119-21 changes. OMMD also requests $110,000 in FY27, $115,000 in FY28, and $125,000 in FY29 to support placement of content on radio and TV to share key messages through multiple channels with impacted communities. Community engagement has consistently elevated radio as a key strategy to reach greater Minnesota.

OMMD also requests $250,000 in FY27 and $80,000 in FY28 and FY29 to support the production and distribution of videos with key messages that will target 13 languages and communities, and $50,000 in FY27 and $25,000 in FY28 and FY29 to support DHS-led paid search and social media costs.

Dollars in Thousands

Net Impact by Fund			**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
General Fund			-	124	124	(18,959)	(17,504)	(36,463)
		Total All Funds	-	124	124	(18,959)	(17,504)	(36,463)
Fund	**BACT**	**Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	33ED	MA Grants	-	(674)	(674)	24,947	37,435	62,382
GF	33AD	MA Grants	-	(10,253)	(10,253)	(58,690)	(70,173)	(128,863)
GF	33FC	MA Grants	-	(1,096)	(1,096)	(3,371)	(3,480)	(6,851)
GF	51	HCA OMMD Community Minigrant Program	-	1,250	1,250	1,250	625	1,875
GF	51	Health Care Navigator Incentive Payments	-	250	250	500	500	1,000
GF	13	HCA Admin FTEs - (45.5, 45.5, 45.5, 45.5)	-	6,669	6,669	7,762	7,762	15,524
GF	11	Ops Admin FTES (4, 4, 4, 4)	-	686	686	820	820	1,640

GF	13	HCA Admin FTEs - (8, 8, 8, 8)	-	1,112	1,112	1,293	1,293	2,586
GF	13	HCA OMMD Community Outreach Communications	-	1,005	1,005	318	830	1,148
GF	13	PMO Administrative Contracts	-	4,000	4,000	4,000	4,000	8,000
GF	13	HCA Admin Contract – NCOA and Non Federal Hub Verification	-	2,000	2,000	2,000	2,000	4,000
GF	13	HCA Direct Enrollee Communications (Mail and translations)	-	110	110	52	52	104
GF	REV1	Admin FFP@32%	-	(4,986)	(4,986)	(5,198)	(5,362)	(10,560)
GF	11	HCA Communications Texting Outreach (@50% FFP)	-	8	8	8	8	16
GF	11	Operations Admin-Systems (IDS) @31% NVH	-	-	-	4,218	5,054	9,272
GF	11	MMIS (State Share @ 29%)	-	-	-	3	3	6
GF	11	MAXIS (State Share @ 55%)	-	43	43	43	43	86
GF	11	METS (State Share @ 38%)	-	-	-	1,086	1,086	2,172

Requested FTEs

Fund	BACT	Description	FY 26	FY 27	FY 25-27	FY 28	FY 29	FY 28-29
GF	13	MMA18K - SMRT	0	2	2	2	2	2
GF	13	MAPE14L - SMRT	0	2	2	2	2	2
GF	13	MAPE11L - SMRT	0	7	7	7	7	7
GF	13	MAPE8L - SMRT	0	3	3	3	3	3
GF	13	MMA18K - SMRT Trainer	0	1	1	1	1	1
GF	13	MAPE14L - HCEO	0	2	2	2	2	2
GF	13	AFSCME Clerical 66 - HCEO	0	5	5	5	5	5
GF	13	MAPE 18L - HRQ	0	2	2	2	2	2
GF	13	MAPE 14L - HRQ	0	1	1	1	1	1
GF	13	MAPE 17L - Federal Relations	0	1	1	1	1	1
GF	13	Manager 17M - Appeals	0	1	1	1	1	1
GF	13	MAPE19L - Appeals	0	5	5	5	5	5
GF	13	AFSCME Clerical 73 - Appeals	0	1	1	1	1	1
GF	13	AFSCME Clerical 65 - Appeals	0	1	1	1	1	1
GF	13	AFSCME Clerical 61 - Appeals	0	0.5	0.5	0.5	0.5	0.5
GF	13	MAPE14L - OMMD	0	1	1	1	1	1
GF	13	MAPE17L - OMMD	0	2	2	2	2	2
GF	13	MAPE18L - OMMD	0	1	1	1	1	1
GF	13	MMA21K - OMMD	0	1	1	1	1	1
GF	13	MAPE14L - HCEA	0	2	2	2	2	2
GF	13	MAPE17L - PMO	0	4	4	4	4	4
GF	11	MMA25K - GCO Staff Level 3 Attorneys	0	3	3	3	3	3
GF	11	MAPE18L - FOD	0	1	1	1	1	1
GF	13	MAPE11L - HCIA	0	4	4	4	4	4

GF	13	MMA18K - HCIA	0	2	2	2	2	2
GF	13	MAPE8L - HCIA	0	2	2	2	2	2

Impact on Children and Families:

Two of the new federal eligibility provisions are likely to have a significant impact on children and families: limiting retroactive MA coverage and restrictions on full MA coverage for certain legal noncitizens. Reducing the MA retroactive period from three months to two months for this population directly impacts their cost for health care services and is likely to result in medical debt for some families. This change is particularly harmful for applicants who seek MA after experiencing life events such as pregnancy or childbirth. For example, a delay in applying following the birth of a child could result in no coverage for the care provided and large hospital bills.

Eliminating full MA coverage for certain legal noncitizens starting October 1, 2026, will impact parents who are not pregnant and who are refugees, asylees, certain abused spouses, trafficking victims, and others granted protection under a humanitarian basis. This change will undermine parental access to preventive and ongoing medical care, quality mental health services and substance abuse treatment.

Six-month eligibility renewals and work requirements do not apply directly to children and families. However, studies of previous changes in Medicaid eligibility show increased child enrollment following adult Medicaid expansions and outreach efforts and increased rates of child uninsurance when barriers to Medicaid enrollment are put in place for adults.

Equity and Inclusion:

While the majority of MA enrollees are white, MA has a disproportionate impact on Minnesotans who are Black, American Indian, Asian, Pacific Islander, and multiracial, covering a larger proportion of these populations in the state. As a result, the new federal Medicaid eligibility requirements enacted as part of Public Law 119-21 will have a disproportionate impact on these populations and, in particular, within these populations those who are MA enrollees who are ages 21 to 64, who do not have dependent children, are not pregnant and not seeking MA based on disability (also referred to as MA Adults without Children or the expansion group).

<u>Limiting Retroactive Medicaid Coverage</u>

The reduction of retroactive MA coverage poses significant risks to health equity in Minnesota. Retroactive coverage protects people who qualify for Medicaid but apply late due to barriers such as documentation, life instability, or health crises. Shortening this period will result in delayed or forgone care and care discontinuity and may lead to worsened health outcomes. It also increases uncompensated care and medical debt, shifting the financial risk to individuals and providers, especially safety-net hospitals and clinics. People facing application and enrollment hurdles—Black, American Indian, rural, immigrant, people with disabilities, housing-insecure, and LGBTQ+ Minnesotans—will feel disproportionate effects because they are more likely to experience application delays and need urgent care during gaps. These groups are more likely to delay enrollment due to life instability, digital or language access gaps, or systemic discrimination and retroactive coverage has long served as a safeguard against those delays.

For providers, particularly in rural and underserved areas, the inability to bill retroactively increases uncompensated care burdens and threatens long-term sustainability.

<u>Six-Month Eligibility Renewals for Certain Medicaid Enrollees</u>

Implementation of six-month eligibility renewals will adversely affect MA enrollees who are Adults without Children. (American Indians are not subject to six-month renewals.) Several studies have found that with expansion of Medicaid, this population has experienced reduced disparities in access to care across race and

ethnicity, income, education level, insurance type and employment status. As stricter eligibility requirements cause individuals to lose MA including more frequent eligibility renewals, this progress is likely to be reversed.

Some enrollees will receive more frequent renewal paperwork if they cannot be automatically renewed using trusted electronic data sources. Eligible individuals are at risk for losing coverage if they do not receive or understand notices or forms, do not respond to requests for information within required timeframes, or other issues unrelated to their actual eligibility status. This can result in a temporary loss of MA coverage in which enrollees disenroll and re-enroll within a short period of time often referred to as "churn." Working individuals whose monthly income fluctuates due to irregular work hours, overtime, or multiple part-time jobs may be more likely to experience churn.

When individuals who remain eligible for coverage are disenrolled, they experience gaps in coverage that limits access to care and leads to delays in getting needed care. Research indicates that enrollees who experience fluctuations in coverage are more likely to report difficulties getting medical care and are more likely to end up in the hospital with a preventable condition. In addition, there are administrative cost associated with disenrolling an enrollee and then subsequently processing a new application.

Work/Community Engagement Requirements for Certain Medicaid Applicants and Enrollees

The imposition of federal work reporting requirements on MA applicants and enrollees who are Adults without Children could deepen racial and geographic disparities in health care access and increase uncompensated care burdens on hospitals and clinics.

Minnesota has made notable progress in addressing racial, geographic, and income-based disparities in health outcomes. However, introducing work reporting requirements would likely reverse these gains by disproportionately impacting communities already experiencing systemic inequities, not due to unwillingness to work, but because of barriers complying with administrative requirements related to documentation, internet access, unstable housing and transportation issues.

MA covers a disproportionate share of Minnesotans who identify as Black, American Indian or Hispanic/Latine. Medicaid coverage rates are higher in rural areas than in the Twin Cities Metro meaning that any negative changes to the MA program will have a disproportionate impact on these communities.

Work/community engagement requirements for MA Adults without Children are expected to lead to coverage loss not only because some individuals will fail to meet the requirements themselves, but also because many may be unable to comply with the added administrative burdens of reporting their work or qualifying exemptions. Individuals with mental health conditions, disabilities, or unstable housing are disproportionately affected by complex documentation requirements. Language barriers also contribute to drops in benefit retention. Studies of a previous effort to implement Medicaid work requirements in Arkansas demonstrated that nearly 25% of enrollees lost coverage primarily due to failure to regularly report work status or document eligibility for an exemption, and enrollees who lost coverage experienced poorer medication adherence, delays in care, and increased medical debt.

Legal Noncitizen Full Medicaid Coverage Restrictions

The new federal provisions end coverage options that have been available to many lawfully residing individuals for decades—including refugees, asylees, victims of human trafficking, and others. As a result, more immigrants will go without health coverage, leading them to face higher barriers to health care, take on more medical costs, or forgo care altogether. It will leave more people uninsured and widen existing coverage and health disparities for noncitizens going forward.

These changes build on other recent and major federal efforts to restrict immigrants' use of health care and other programs, including the expansion of eligibility restrictions under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) to new federal health, nutrition and other programs, the end of Deferred Action for Childhood Arrivals (DACA) recipients' ability to access the Marketplaces, and similar eligibility restrictions enacted in H.R.1 for the Supplemental Nutrition Assistance Program (SNAP). Combined with recent revelations that the federal administration had used Medicaid data for immigration enforcement, these upcoming changes will likely contribute to confusion and chilling effects that prevent immigrants, including eligible individuals, from seeking and finding the coverage and health services they need.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

The reductions in the MA retroactive period will impact American Indians and have a substantial direct effect on Minnesota's Tribal governments and directly impacts American Indians who rely on MA for health care. Delays in applying for MA will increase their cost for health care services and is likely to result in medical debt that may be significant particularly for hospital bills.

Six-month eligibility renewals, work/community engagement requirements, and legal noncitizen full MA coverage restrictions do not apply to American Indians and should not have a direct effect on one or more of the Tribal governments in Minnesota.

Impacts to Counties:

The new federal Medicaid eligibility changes add policy and operational complexity and will require new processes for counties to administer. This is coming at a time when some counties are already struggling to keep up with application and renewal processing for MA and other human services programs such as the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) (known as the Minnesota Family Investment Program (MFIP) in Minnesota). In particular, work/community engagement requirements and six-month renewals are expected to add significant administrative burden to counties. While these changes target the MA Adults without Children population, when county administrative capacity is stretched all enrollees are affected. These changes will drive additional phone calls to counties increasing call wait times, reduce "ex parte" (automated) renewals for the adult population requiring additional paperwork from the enrollee that must be processed by the county, increase the number of appeals, and further delay processing of new applications and renewals.

This proposal will disproportionally impact counties with larger numbers of MA enrollees who are Adults without Children.

IT Costs:

<u>Limiting Retroactive Medicaid Coverage</u>

Changes are required in METS and MAXIS systems to implement shorter MA retroactive coverage periods based on eligibility status. Work will begin in the current fiscal year to implement this change and this legislative proposal reflects only ongoing, operational costs.

<u>Obtaining Enrollee Address Information</u>

There are no systems costs associated with this provision.

Six-Month Eligibility Renewals for Certain Medicaid Enrollees

Changes are required in METS and MAXIS systems to run renewals for the MA Adults without Children population on a six-month renewal cycle and to exclude people who are American Indians or Alaska Natives from six-month renewals. Work will begin in the current fiscal year to implement this change and this legislative proposal reflects only ongoing, operational costs.

Work/Community Engagement Requirements for Certain Medicaid Applicants and Enrollees

Changes are required in METS to implement work/community engagement requirements for the MA Adults without Children population. Work will begin in the current fiscal year to implement this change and this legislative proposal reflects only ongoing, operational costs.

Legal Noncitizen Full Medicaid Coverage Restrictions

Changes are required in METS, MAXIS, and MMIS systems to implement the updated MA legal noncitizen status definition changes. Work will begin in the current fiscal year to implement this change and this legislative proposal reflects only ongoing, operational costs.

Category	***FY 2026***	***FY 2027***	***FY 2028***	***FY 2029***	***FY 2030***	***FY 2031***
Payroll		$78,296	$2,945,392	$2,945,392	$2,945,392	$2,945,392
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)						
Total		$78,296	$2,945,392	$2,945,392	$2,945,392	$2,945,392
MNIT FTEs						
Agency FTEs						

Results:

Measure	**Measure type**	**Measure data source**	**Most recent data**	**Projected change**
Briefly write what is being measured.	*Select quantity, quality, or result. Please try to include 1 of each.*	*Describe how the data for this measure will be collected.*	*If currently collected, provide most recent data for this measure. If not currently collected, please write N/A.*	*If successful, describe the change expected on this measure and to what extent.*
Retroactive MA eligibility	Number of months	Enrollment data	Data is currently collected	Retroactive MA is limited to one or

Measure	Measure type	Measure data source	Most recent data	Projected change
				two months for the individual (based on their MA eligibility group)
Enrollee address information	Number of address updates	Enrollment data	Data is currently collected	The U.S.P.S. National Change of Address Data Base will be used to update enrollee addresses
Eligibility renewals for MA Adults without Children	Six-month renewals	Enrollment data	Currently the average monthly cohort for annual renewals for this group is 18,750 enrollees	Eligibility renewals are conducted every six-months for MA Adults without Children
Work/community engagement requirements for MA Adults without Children	Work/community engagement requirements	Enrollment data	DHS estimates that of the 225,000 adults without children, 128,000 or 56.8% will be subject to the new work requirements	Work/community engagement requirements are applied unless an individual is exempt
Legal noncitizen full MA coverage restrictions	Qualifying immigration status as redefined by federal law	Enrollment data	Immigration status is currently collected but revisions will be needed in the eligibility systems to comport with the new federal law	Only noncitizens with an MA qualifying immigration status are approved for full MA coverage and legal noncitizens without such a status are not approved

Statutory Change(s):

Limiting Retroactive Medicaid Coverage – Minnesota Statutes, §256B.056, subd. 3d; and §256B.061

Obtaining Enrollee Address Information – Minnesota Statutes, §256B.04

Six-Month Eligibility Renewals for Certain Medicaid Enrollees – Minnesota Statutes, §256B.056, subd. 7 and 7a

Work Requirements for Certain Medicaid Applicants and Enrollees – Minnesota Statutes, §256B.056

Legal Noncitizen Full Medicaid Coverage Restrictions – Minnesota Statutes, §256B.06

Department of Human Services
FY 2026-27 Biennial Budget Change Item

Change Item Title: Federal Compliance: HR-1 Financing Related Response (HC-47)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	1,334	1,040	1,040
Revenues	0	0	0	(411)
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	1,334	1,040	629
FTEs	**0**	**8**	**8**	**8**

Request:

The Governor recommends implementing changes to conform with the financial provisions of federal legislation HR-1. Components of this proposal include:

- A technical change to require that Commissioner of the Department of Human Services (DHS) be consulted in the event the Commissioner of Minnesota Management and Budget (MMB) considers reducing the 1.8% MinnesotaCare Provider Tax.
- Implementing Medical Assistance cost-sharing as required in the federal reconciliation bill (HR1), Section 71120 for enrollees who are adults without children with incomes between 100 and 133% of the federal poverty level (FPL).
- Establishing a ceiling of $1,000,000 for permissible home equity values for individuals when determining eligibility for Medical Assistance for payment of long-term care services (MA-LTC).
- Strengthening Medicaid program oversight and support for county and tribal nation partners to increase eligibility determination accuracy and audit preparedness.

Rationale/Background:

<u>MinnesotaCare Provider Tax Technical Change</u>

On July 3, 2025, Congress passed the 2025 reconciliation bill (H.R. 1), which included a provision that prohibits states' authority to create new or increase existing Medicaid provider taxes beyond the tax revenue percentage collected at the time the new federal law took effect. Minnesota utilizes a provider tax, known as the MinnesotaCare Provider Tax to support funding the MinnesotaCare program and other programs targeted at creating affordable access to health care services. Minnesota Statute 295.52 defines the current provider tax as 1.8% of gross receipts that health care providers receive for providing patient services in Minnesota and allows the Commissioner of MMB to reduce the tax percentage to balance projected tax revenues and expected expenditures. Any such reduction is only valid for one calendar year before returning to the amount designated by statute. This occurred in 2023, when MMB reduced the MinnesotaCare Provider Tax from 1.8% of gross receipts to 1.6%.

In light of the new federal law, however, if the circumstances described under Minnesota Statute 295.52, Subdivision 8, paragraph (b) occur, the DHS should be consulted before reducing the tax rate. DHS will need to review the proposed adjustment to ensure compliance with all regulations and guidance implementing H.R. 1.

<u>Cost Sharing for MA Adult without Children</u>

Historically, federal regulations allowed states to impose nominal cost sharing on certain Medicaid recipients and

services. Minnesota charged nominal cost sharing until 2024, when the legislature repealed all cost-sharing for Medical Assistance effective January 1, 2024.

Section 71120 of the federal reconciliation bill requires states to impose cost-sharing for the adult expansion population with incomes between 100 and 133% FPL. In Minnesota, this is the MA Adults without Children eligibility group, which consists of individuals ages 21 through 64, who do not have dependent children, are not pregnant and not seeking MA based on disability. This is the only Medicaid eligibility group impacted by this change. People who are American Indians and Alaska Natives are exempt from the requirement as well as the following services under current law: primary care, mental health, and substance use disorder services. It also exempts services provided by federally qualified health centers, behavioral health clinics, and rural health clinics. The law requires that cost sharing of up to $35 per service or item and that total aggregate cost-sharing may not exceed more than 5% of an individual or family's monthly or quarterly income. States must implement this change by October 1, 2028.

Home Equity Limit for MA Payment of Long-Term Care Services

Since 2005, a home equity limit has been part of the eligibility determination for individuals seeking MA for payment of long-term care services (MA-LTC). To qualify for MA-LTC, people who own a home must have a home equity value at or below the home equity limit. In 2011, the Minnesota State legislature clarified that the home equity value for eligibility would be increased year over year based on the percentage increase in the Consumer Price Index. The home equity limit is currently $730,000. An individual is exempt from the home equity limit if they have a spouse or child with a disability living in the house. This proposal conforms with new federal law that establishes a ceiling for the home equity value of $1,000,000.

Strengthening Medicaid Eligibility Determination

Minnesota's county and tribal partners are the frontline in Medicaid eligibility determinations, which are subject to audit review. Counties and tribal nations currently lack consistent, hands-on support to interpret audit results, develop effective corrective action plans, and implement changes to prevent future errors. Without this collaboration, local agencies struggle to identify where mistakes occur in the Medicaid eligibility determination process and how to prevent them in the future, resulting in repeated errors and greater financial risk for the state.

With additional staff resources, DHS can work more directly with these partners to provide training, feedback, and agency-specific corrective action planning that supports accurate Medicaid eligibility decisions.

This proposal aligns with statewide efforts to improve efficiency, reduce state spending, and support local agencies in delivering high-quality eligibility determinations. Likewise, this proposal is aimed to decrease the risks associated with compliance error rates outlined in Federal Statute.

Federal law restricts the allowable Medicaid eligibility error rate to three percent. Any overpayments above this threshold become the state's financial responsibility. Minnesota's eligibility error rate is measured through federal reviews such as the Payment Error Rate Measurement (PERM) audit, as well as state-conducted Medicaid Eligibility Quality Control (MEQC) audits. Recent changes in federal law (H.R.1, §71106, effective FY 2030) expand the definition of improper payments to include payments where insufficient information is available to confirm eligibility. These upcoming changes also allow for additional audits to impact a state's error rate, including state-conducted audits.

Minnesota currently risks exceeding the 3% error rate threshold, which could trigger federal recoupment of excess payments. Preventing eligibility determination errors is essential to protect Minnesota's access to federal Medicaid funding.

Potential Financial Risk from Exceeding the 3% Error Rate Threshold

Under current federal law (Social Security Act §1903(u); 42 U.S.C. 1396b(u)(1)), the federal government may

recoup the full federal share of payments above a three percent error rate. Although recoupments associated with the PERM audit have not historically occurred, the federal authority to recover them exists and may be enforced in the future.

The Centers for Medicare & Medicaid Services (CMS) has not yet provided details on the method in which state error rates will be calculated effective FY 2030. Without this, firm calculations on state's potential liability associated with this change is not currently possible; however, the inclusion of MEQC and other audits in the calculation is expected to increase Minnesota's overall financial risk.

Proposal:

MinnesotaCare Provider Tax Technical Change

MinnesotaCare Provider Tax applies to all health care providers and employers of health care providers regulated by the state of Minnesota, those who provide patient services or employ or contract with a health care provider to perform patient services, those who sell or repair hearing aids or prescription eyewear, and licensed (non-volunteer) ambulance service providers. The MinnesotaCare Provider Tax has been in effect since 1992 and was originally set at 2% of gross receipts that health care providers receive for providing patient services in Minnesota. In 2019, the Minnesota State Legislature passed a law to reduce the MinnesotaCare Provider Tax to 1.8% of gross receipts. The funding generated from this tax is deposited into the Health Care Access Fund and are used to fund the MinnesotaCare program and other programs with the goal of supporting affordable access to healthcare services.

In 2011, the Minnesota State Legislature passed a law that requires the Commissioner of MMB to project the balance in the HCAF each year and determine if revenues will exceed 125% of needed expenditures. If so, the Commissioner is instructed to reduce the tax to balance revenues and expenses in consultation with the commissioner of the Department of Revenue. This proposal requests the commissioner of the DHS to also be consulted, so to ensure tax reductions and increases conform with federal law. This proposal is budget neutral and would not impact the funds generated and deposited into the Health Care Access Fund. This change will preserve and protect the MinnesotaCare Provider Tax in light of new federal law changes that prohibit states' authority to increase existing provider taxes beyond the percentage set in law upon effect of H.R.1. This proposed change would be effective upon enactment.

Cost Sharing for MA Adult without Children

The Governor proposes to implement cost sharing for MA Adults without Children with incomes between 100 and 133% FPL, who do not meet the exemptions noted above. To effectuate these requirements, systems changes will be necessary to configure cost sharing for appropriate services and households, track cost sharing received to ensure payments do not exceed the federal maximum of 5% of income, stop charging cost sharing for individuals meeting the federal maximum, and generate timely notification for said individuals.

The IT system impacted by this proposal includes the Medicaid Management Information System (MMIS), Minnesota' automated system for payment of medical claims and capitation payments, and systems edits will be needed to implement the requirements. The effective date of this proposal is assumed to be October 1, 2028.

Home Equity Limit for MA Payment of Long-Term Care Services

This proposal establishes a ceiling of $1,000,000 for permissible MA-LTC home equity values. In practice, this change will take effect in several years, when the home equity limit indexes to be higher than $1,000,000. When this occurs the home equity value permissible to be eligible for long-term care services will remain a static $1,000,000. DHS anticipates that the year over year increase based on the Consumer Price Index will not reach $1,000,000 within the budget horizon. This proposal is assumed to be effective January 1, 2028.

Strengthening Medicaid Eligibility Determination

Minnesota can proactively work to decrease health care eligibility errors through the development of strong

partnerships with county and tribal agencies by expanding the Program Integrity and Oversight Unit with dedicated staff, while simultaneously bolstering the state's audit readiness. This proposal aims to:

- Reduce the risk of exceeding the three percent error rate cap to avoid or limit state costs, financial penalties, and disallowances.
- Identify and correct eligibility processing and system errors before audits are conducted.
- Provide consistent, proactive outreach and technical assistance to counties and tribal agencies that pertains to the individual entity.
- Ensure compliance with federal and state Medicaid and MinnesotaCare eligibility requirements.
- Strengthen corrective action development, implementation, and monitoring.
- Improve overall program integrity to ensure equitable and accurate access to health care coverage for eligible Minnesotans.

This proposal would expand the Health Care Eligibility Program Integrity and Oversight (PIO) Unit by adding 8 FTEs dedicated to regional county and tribal nation outreach and support, error prevention and reduction, and compliance with federal and state requirements for Medicaid and MinnesotaCare eligibility.

Lead agencies currently have access to various reports which they are expected to follow up on. The additional FTEs would provide capacity for periodic oversight of reports to ensure reports are not only understood by each agency, but that they are completed with timeliness in mind.

The assumed effective implementation date for this proposal is July 1, 2026.

Fiscal Impact

To support strengthening the Medicaid eligibility determination process, 8 full time employees (FTEs) are required. These FTEs include:

- 6 MAPE 14 FTE – new program integrity specialist/analysts to focus on county and tribal compliance and error reduction starting July 1, 2026.
- 1 Supervisor 3 – to lead the additional staff starting July 1, 2026.
- 1 MAPE 18L FTE – to support increased report needs for program integrity purposes starting October 1, 2026.

Net Impact by Fund (dollars in thousands)			FY 26	FY 27	FY 26-27	FY 28	FY 29	FY 28-29
General Fund			-	1,334	1,334	1,040	629	1,669
HCAF								
Federal TANF								
Other Fund								
Total All Funds			-	1,334	1,334	1,040	629	1,669
Fund	**BACT#**	**Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	REV2	Cost Sharing Revenue	-	-	-	-	(411)	(411)
GF	11	MMIS (State Share @ 29%)	-	85	85	34	34	68
GF	11	METS (State Share @ 38%)	-	221	221	44	44	88
GF	11	FileNet (State Share @ 50%)	-	3	3	1	1	2
GF	13	Admin (FTE 0, 0, 8, 8, 8)	-	1,507	1,507	1,413	1,413	2,826
GF	REV1	Admin FFP @ 32%	-	(482)	(482)	(452)	(452)	(904)
FTE Description								
Fund	**BACT#**	**FTEs Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	13	MAPE 14L PIO Specialists	0	6	6	6	6	6
GF	13	MMA 21 PIO Supervisor	0	1	1	1	1	1
GF	13	MAPE 18L EDQ Research Scientist	0	1	1	1	1	1

Impact on Children and Families:

MinnesotaCare Provider Tax Technical Change

This technical change does not have a direct impact on children and families, but rather aims to ensure that any changes to the 1.8% MinnesotaCare Provider Tax conform with federal law.

Cost Sharing for MA Adult without Children

This budget proposal does not impact children and families, as federal law requires states to charge cost-sharing only for MA Adults without Children. Children and families would continue to receive services without cost-sharing.

Home Equity Limit for MA Payment of Long-Term Care Services

Setting a ceiling or limit on the home equity value could eventually impact some applicants who would not be eligible for MA payment of long-term care services if their home has an equity value greater than $1,000,000.

Strengthening Medicaid Eligibility Determination

This proposal builds on best practices from public, private, and tribal agencies through the ability to promptly address common errors directly with county and tribal nations for targeted, hands-on support, therefore increasing equity in access to resources at a state level. Accurate health care eligibility determinations allow children to maintain a healthy start to life and help Minnesotans eligible for Medicaid to access needed mental health supports while also receiving consistent coverage for preventative care.

Data from PERM and MEQC audits indicate ongoing errors in eligibility determination; by proactively addressing these errors, this proposal will protect program funding, allowing the state to continue to provide health care to Minnesota residents eligible for Medicaid and improve health outcomes for the next generation of Minnesotans.

Equity and Inclusion:

MinnesotaCare Provider Tax Technical Change

This technical change does not have a direct impact on equity, but rather aims to ensure that any changes to the 1.8% MinnesotaCare Provider Tax conform with federal law.

Cost Sharing for MA Adult without Children

Implementation of the proposal will not address inequities for people of color, people in the LGBTQ community, or other protected classes or Veterans. Native Americans and people with disabilities will not be subject to the new cost-sharing requirements, as they are typically either exempt or outside of the MA Adults without Children.

The new cost sharing requirements for MA Adults without Children will not have a specific negative impact for people of color, people in the LGBTQ community or other protected classes or Veterans, but any person who is a member of one of these groups and a person with a MA Adult without Children basis of eligibility has the potential to be negatively impacted by the new charges. Studies have shown even modest increases in cost-sharing can lead to avoidance of care, which can lead to more expensive care and more serious health risks. This proposal could reduce health care affordability for individuals subject to the new charges.

These changes come with federal law changes enacted as part of HR 1. Those impacted by these changes were not consulted. The agency will need to develop messaging for the impacted MA Adults without Children population to ensure they understand the new cost-sharing charges.

Home Equity Limit for MA Payment of Long-Term Care Services

The home equity value limit is applied consistently for all MA-LTC applicants.

Strengthening Medicaid Eligibility Determination

This proposal is designed to reduce inequities in access to Medicaid and MinnesotaCare by ensuring accurate eligibility determinations for all populations, including people of color, Native Americans, individuals with disabilities, LGBTQ+ communities, other protected classes, and veterans. By providing dedicated staff to work directly with counties and tribal agencies on areas that pertain to their individual agency, the state can proactively address errors that disproportionately affect vulnerable populations.

Counties, tribal nations, and relevant stakeholders will be consulted during implementation to identify common eligibility challenges and ensure targeted support improves outcomes. The additional DHS staff will actively collaborate with these partners to gather feedback, address concerns, and refine corrective action strategies that pertain to the individual agency.

DHS staff will maintain ongoing outreach with counties and Tribal agencies, providing guidance, training, and updates on corrective actions. Stakeholders will receive regular communications to address questions or concerns and ensure transparency.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

Minnesota Tribal agencies that administer Medicaid and MinnesotaCare eligibility determinations will benefit from dedicated DHS staff providing hands-on technical assistance, support with corrective action plans, and guidance on reducing eligibility errors. This will improve program integrity and ensure equitable access to health care coverage for tribal members.

Tribal partners have expressed interest in enhanced support for eligibility oversight and corrective action, making this proposal a positive step in strengthening Tribal-state collaboration. DHS staff will collaborate closely with tribal agencies during implementation to review audit findings, develop tailored corrective action plans, and ensure tribal input informs support strategies.

DHS staff will maintain regular outreach with Tribal agencies, providing updates, guidance, and opportunities for feedback. Questions or concerns from Tribal partners will be addressed promptly to ensure transparent and collaborative communication.

Other provisions in this proposal do not directly impact Minnesota Tribal Governments.

Impacts to Counties:

There is no financial impact to county and tribal nations tied to this proposal.

This proposal will benefit county and tribal nations by providing dedicated DHS staff to support program integrity and corrective action planning. County operations will positively be impacted by having subject matter experts available to address frequently cited audit errors and tailored guidance for the county or tribal nation. This support strengthens the processes in place by offering focused, hands-on assistance rather than audit errors being addressed broadly, on a state-wide level.

No disparities have been identified in relation to this proposal. All counties and tribal agencies will have access to a designated DHS staff with assigned support areas of comparable size, ensuring equitable access to technical assistance and program oversight.

Planned engagement with agencies will occur during implementation. DHS staff will work directly with lead agency partners to identify common eligibility challenges, provide guidance on corrective action plans, and ensure audit findings are addressed effectively and consistently. Feedback received from county and tribal nations welcomed the idea of support from regional representatives in the form of corrective action planning and audit preparedness.

IT Costs

Systems changes are needed in MMIS, METS, and FileNet to implement the reinstatement of cost sharing in this proposal.

Category	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*	*FY 2030*	*FY 2031*
Payroll	$882,925	$176,584	$176,584	$176,584	$176,584	$176,584
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)						
Total	**$882,925**	**$176,584**	**$176,584**	**$176,584**	**$176,584**	**$176,584**
MNIT FTEs						
Agency FTEs						

Results:

The Results section is intended to display the performance measures that will be used to assess the success, outcomes, and impact of the proposed change item. Please complete this section based on the current proposal with recognition that performance measures may change based on revision processes and final budget allocation. All portions of the Results section are required. Examples of performance measures and a brief video with guidance for this section is available online at Results Management Resources for State Agencies. Please contact the Results Management Team at MMB (ResultsManagement@state.mn.us) with questions and for support completing this section.

Part A: Performance Measures

Overall Goal and Expected Outcomes:

The goal of this proposal is to strengthen program integrity in Medicaid and MinnesotaCare eligibility determinations with additional dedicated staff to provide direct technical assistance, oversight, and corrective action support to counties and Tribal agencies in an effort to reduce audit error rates (PERM and MEQC), improve corrective action planning, and enhance compliance with federal eligibility requirements. Success will be measured over the first 3–5 years following implementation through audit results and compliance metrics.

Evidence of Expected Outcomes:

Federal and state audit data (PERM and MEQC) demonstrate ongoing eligibility errors across counties and Tribal

agencies. Evidence indicates that providing dedicated oversight and proactive technical assistance reduces error rates, strengthens corrective action implementation, and improves overall compliance. Historical trends show that errors are concentrated in certain administrative processes, suggesting targeted interventions by DHS staff will effectively reduce errors.

Measure	**Measure type**	**Measure data source**	**Most recent data**	**Projected change**
Briefly write what is being measured.	*Select quantity, quality, or result. Please try to include 1 of each.*	*Describe how the data for this measure will be collected.*	*If currently collected, provide most recent data for this measure. If not currently collected, please write N/A.*	*If successful, describe the change expected on this measure and to what extent.*
PERM Medicaid Eligibility Audit Error Rate	Medicaid Eligibility error Rate	PERM 2022 PERM 2025	.70% Error Rate Not Yet Available	Maintain or decrease in error rate
PERM CHIP Eligibility Audit Error Rate	CHIP Eligibility Error Rate	PERM 2022 PERM 2025	10.46% Error Rate Not Yet Available	Decrease in error rate
MEQC Error Rate	Eligibility Error Rate	MEQC 2022	20.38% Error Rate	Decrease in error rate
Timeliness or Report Completion	Process Completion	Agency-Submitted Reports	N/A	Projected increase in on-time completion

Statutory Change(s):
Minnesota Statute, Section 295.52, Subdivision 8

Minnesota Statute Section 256B.056, subdivision 2a(a): “The amount specified in this paragraph shall be increased beginning in year 2011, from year to year based on the percentage increase in the Consumer Price Index for all urban consumers (all items; United States city average), rounded to the nearest $1,000**, not to exceed $1,000,000**."

§256.01, Subdivision 4 Duties of State Agency
Sec. 256B.0631 MN Statutes

Department of Human Services
FY 2026-27 Biennial Budget Change Item

Change Item Title: Human Services Contingency Account (OP-02)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	10,000	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	10,000	0	0
FTEs	**0**	**0**	**0**	**0**

Request:
The Governor recommends an investment of $10,000,000 from the general fund in fiscal year 2027 to the Human Services Response Contingency Account. These contingency account funds will be available for the Commissioner of Human Services to deploy resources to respond to immediate needs related to supporting the health, welfare, or safety of the people of Minnesota and for which no other funding source is available.

Rationale/Background:
In recent years, Minnesota's human services programs have experienced growing demands while federal funds supporting critical services to Minnesotans have been reduced or stand to be reduced ad hoc. Today, there is less predictability in federal resources across the board than at any time in recent memory. There is also growing demand of behavioral health, housing, healthcare, and other human services created by economic uncertainty and other impacts of federal actions.

The Human Services Response Contingency Account was created by the 2024 legislature to provide the state with flexible resources to address urgent needs that arise between legislative sessions and outside the regular budget process. The Human Services Response Contingency Account is structured similarly to the Public Health Response Contingency Account, which provides nimbleness and flexibility for rapid response when circumstances require it. The 2024 legislature authorized a one-time appropriation of $4 million. As of February 2026, the funds in this account have been fully expended.

Proposal:
This proposal adds $10,000,000 to the Human Services Response Contingency Account in the Special Revenue Account to enable the state to provide support to people and communities where there are emerging or immediate needs related to supporting the health, welfare, or safety of people, particularly in the face of uncertainty and unpredictability around future federal action.

This proposal replenishes funds to an existing account and does not a change to an existing program. This funding would be used when unforeseen circumstances arise, there are impacts to Minnesotans impacting the health, welfare, and safety of people, and no other funding source is available to respond to the urgent need. Without this resource, the Department of Human Services may be unable to respond to urgent needs, leaving vulnerable populations without timely support.

Fiscal Impact:

Dollars in Thousands

Net Impact by Fund			FY 26	FY 27	FY 25-27	FY 28	FY 29	FY 28-29
General Fund			0	10,000	10,000	0	0	0
Other Fund 1								
Other Fund 2								
		Total All Funds	0	10,000	10,000	0	0	0
Fund	**BACT**	**Description**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	48	Human Services Response Contingency Account	0	10,000	10,000	0	0	0
Fund	**BACT**	**Description**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**

Impact on Children and Families:
The Human Services Response Contingency Account allows the Commissioner to respond to the emergency needs of Minnesotans, including children and families, in a flexible and timely manner. In a time of large federal budget cuts and ongoing fiscal uncertainty, the flexibility created through the Human Services Response Contingency Account is crucial to enable the State to address unforeseen human services needs for Minnesotans.

Equity and Inclusion:
Equity analysis will be conducted related to uses of the funds.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Tribal Nations may be impacted depending on the use of the funds.

Impacts to Counties:
Counties may be impacted depending on uses of the funds.

IT Costs:
This proposal does not have any IT costs.

Results:
Outcomes will be measured for all uses of the funds and these will be dependent on each use. Measures will include how many people are impacted by the funds deployed and how they were impacted.

Statutory Change(s): Appropriation

Department of Human Services
FY 2026-27 Biennial Budget Change Item

Change Item Title: Modernizing Program and Payment Integrity Safeguards (OP-44)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	(167,873)	1,419	(5,404)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	(167,873)	1,419	(5,404)
FTEs	**0**	**28**	**28**	**28**

Request:
The Governor recommends investments to design and implement a comprehensive systems approach to reduce fraudulent, wasteful or abusive billing practices in Minnesota's public health care programs. By incorporating comprehensive technology and data-driven enhancements to the systems supporting Medical Assistance, critical program integrity processes will be improved.

Rationale/Background:
Across the nation, increasingly sophisticated fraud and abuse schemes threaten the integrity of the health care system, exploiting outdated systems not designed for modern oversight. Minnesota's Medicaid program faces the same challenge: bad actors are adapting faster than traditional safeguards can respond, exposing gaps in aging technology, disconnected data, and manual processes that were built for a different era.

Every dollar lost to fraud, waste, or abuse is a dollar that cannot support Minnesotans who rely on care — whether a senior receiving home supports, a person with disabilities accessing vital therapies, or a family ensuring their child receives essential behavioral health services. Protecting the integrity of Medicaid is not only about reducing losses; it's about protecting people, strengthening public trust, and ensuring that limited resources reach those who truly need them.

The urgency for modernization has grown as federal oversight expectations increase, improper payment rates rise nationally, and fraud tactics become more coordinated, and data driven. The U.S. Center for Medicare and Medicaid Services (CMS) have called on states to implement risk-based, data-informed oversight systems that connect licensing, payment, and audit functions. Minnesota has an opportunity to be among the leaders in this next generation of program and payment integrity — moving from fragmented, reactive processes to a proactive, adaptive model that integrates prevention, detection, and continuous improvement.

Today, Minnesota's oversight systems remain reactive and fragmented:

- **At payment**, claims are reviewed primarily after funds have been disbursed, creating long delays before fraudulent or improper claims are identified.
- **After payment**, valuable lessons from audits and investigations are not systematically fed back into earlier prevention stages, leaving the system vulnerable to recurring patterns of abuse.

Yet advances in data integration, verification, and analytics make it possible to detect unusual billing patterns and identify risks. Minnesota can build a program integrity system that promotes early fraud detection, strengthens oversight across programs, and adapts as risks evolve — in alignment with *CMS's Comprehensive Medicaid Integrity Plan (2024–2028)*.

Proposal:
Minnesota will unify oversight across the provider and payment lifecycle — ensuring that every provider, claim, and dollar is verified, validated, and accountable. This comprehensive modernization links licensing, enrollment, claims review, and auditing into a single, adaptive framework that protects both taxpayers and Minnesotans who rely on care.

This proposal provides a comprehensive, data-based approach to enhance program integrity controls in the Minnesota Health Care Programs (MHCP). This proposal will modernize Department of Human Services (DHS) systems and provide administrative funding to implement end-to-end program integrity measures in the DHS claims adjudication and payment process, including:

1. Enhanced ongoing comprehensive prepayment review of claims to prevent fraudulent billing prior to claims being paid
2. Establishing comprehensive post-payment review of paid claims to identify potential outliers, unexpected trends, and isolate claims, providers, and/or services to refer for investigation; and
3. Deploying predictive analytics and machine learning to continually inform prepayment review, post-payment review, program integrity investigations, and future Medicaid benefit design related to administration of program policies and regulations.

Implementing technology solutions and streamlining processes will promptly identify fraud schemes or overpayments and promote timely recovery of funds. This proposal strengthens oversight at every stage of the provider and payment lifecycle.

Enhanced Prepayment Review and Real-Time Claim Risk Analysis
Today, all claims seeking reimbursement for Medicaid services go through an adjudication process in the Medicaid Management Information System (MMIS). This occurs regardless of the claim's final disposition – whether its paid, denied or suspended. The adjudication process includes thousands of system edits within MMIS that review information to ensure claims meet multiple requirements, including verifying that claims are appropriated to eligible members, that providers billing the claim are actively enrolled to provide the specific service billed, and that the dates of service and services are not duplicative of another previously submitted claim for the same date of service and procedure code. The Medicaid Payment and Provider Services (MPPS) Division within the Health Care Administration (HCA) at DHS currently implements system-coded thresholds to ensure that the number of units does not exceed policy limits established when the service was defined, and it ensures that procedure and diagnosis codes are appropriately attached to each claim.

In response to the Governor's Executive Order 25-10, DHS established a contract with a vendor to begin enhancing prepayment review technology. This contract aims to prevent improper payments in the Medicaid fee-for-service (FFS) program specifically for 14 high risk Medicaid services. A review of three years of previous claims will be used to inform and develop a claims edit assessment that will aim to enhance prepayment review mechanisms.

Funding in this proposal will be used to support an ongoing enhanced prepayment claims analysis contract that will be established through a competitive request for proposal (RFP) process. This contract will establish ongoing prepayment claims analysis technology and expand analysis from the 14 high risk Medicaid services, to review all MMIS adjudicated claims for Medicaid services. The entire effort to establish enhanced prepayment review will result in more robust analytics to identify planned payments that seem suspicious including excessive billing,

duplicate claims, or geographic and temporal anomalies. The technology will build on and reference existing claims edits infrastructure, prior authorization criteria and will continuously refine the prepayment review analytic module to automate fraud detection and payment integrity based on findings over time. Finally, this funding will support the development of collaborative dashboards for program and policy staff to review and escalate flagged claims prior to payment.

Overall, this effort will support preventing fraud, waste, and abuse that occurs between the adjudication and payment of fee-for-service claims that are submitted to DHS for services provided to individuals enrolled in Medicaid and support the goal to detect and prevent improper payments before funds are released, reducing financial exposure and improving accountability.

In addition to the systems and administrative costs to implement prepayment review, this proposal assumes programmatic impacts based on data analysis on the initial roll-out of prepayment review of select services. This proposal assumes that the additional claims subject to prepayment review will be paid one warrant cycle later than the current forecast assumes, shifting spending from one fiscal year to the next. This proposal also assumes small ongoing impacts to forecasted spending due to an increase in denied claims and a reduction in claims submitted.

Post-Payment Review, Audit Modernization, and Feedback Integration

This proposal will also modernize the systems that identify, investigate, and recover improper payments after disbursement and ensure findings directly inform prevention and risk models. Whereas the previous component implements a comprehensive pre-payment review system, this component of the proposal enables comprehensive review of claims after payments are made.

Funding would support:

- Configuration of a unified case management system and development of an analytics platform integrating audit data, investigations, and outcomes.
- Deployment of advanced data-matching and network analysis to uncover shared ownership, addresses, or payment flows among providers or recipients.
- Integration of post-payment findings into prepayment rules and provider risk models, creating a continuous feedback loop.
- Development of audit dashboards, workflow automation, and reporting tools to improve transparency and timeliness.
- Specialized integration and migration support for data sharing across OIG, MMIS, MFCU, and MCOs.

Outcome: This proposal will streamline audit and investigation processes, result in faster fraud detection and stronger recoveries, and enhance the system as a whole by providing a continually improving oversight system that closes gaps over time.

Unified Analytics Infrastructure, Data Integration, and Workforce Capacity

Lastly, this proposal will build the technical foundation and expertise needed to sustain modern program integrity and ensure adaptability as fraud schemes evolve through improvements in data infrastructure and workforce capacity.

Funding would support:

- Expansion of secure data infrastructure and interoperability tools connecting licensing, claims, and audit systems.
- Deployment of analytic and visualization platforms (e.g., Databricks, Tableau, or equivalent) to support timely decision-making.
- Recruitment and training of dedicated analytics and system engineering staff within DHS and MNIT.

- Creation of a program integrity analytics governance group to oversee data quality, performance, and model updates.
- Specialized implementation and integration support from experienced partners.
- Development of ongoing training to build in-house expertise and reduce long-term vendor dependence.

This proposal will provide capacity to detect, prevent, and respond to emerging fraud trends, ensuring continuous improvement and fiscal stewardship.

This modernization makes program integrity about more than compliance — it's about trust, access, and accountability. It gives DHS the tools to prevent fraud before it starts, protect the programs Minnesotans rely on, and ensure every public dollar is used for its intended purpose.

By investing now, Minnesota will not only reduce improper payments but also build a sustainable, self-improving oversight system — one that learns from its own data, adapts to emerging risks, and safeguards care for generations to come.

Modernizing program and payment integrity is not simply about stopping fraud; it's about strengthening trust in public institutions, ensuring every Medicaid dollar is spent with integrity, every provider is accountable, and every Minnesotan can depend on the care they deserve.

Fiscal Impact:

Net Impact by Fund (dollars in thousands)			FY 26	FY 27	FY 25-27	FY 28	FY 29	FY 28-29
General Fund			-	(167,873)	(167,873)	1,419	(5,404)	(3,985)
		Total All Funds	-	(167,873)	(167,873)	1,419	(5,404)	(3,985)
Fund	**BACT**	**Description**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	11	HCA MPPS Admin FTEs for prepayment (@29% state share) (0, 8, 8, 8)	-	344	344	404	404	808
GF	18	OIG post-payment FTEs (0, 20, 20, 20)	-	3,259	3,259	3,873	3,873	7,746
GF	REV1	REV1 Admin FFP @32%	-	(1,043)	(1,043)	(1,239)	(1,239)	(2,478)
GF	11	Prepayment Vendor services one-time implementation (50% FFP)	-	2,500	2,500	-	-	-
GF	11	Prepayment Vendor services (prepay edit, assessment) (50%FFP)	-	3,750	3,750	3,750	3,750	7,500
GF	11	API Vendor (50%FFP)	-	955	955	191	191	382
GF	11	MMIS – Development (71%FFP)	-	331	331	66	66	132
GF	11	MNIT support for Ongoing Enhanced Prepayment Review (50%FFP)	-	704	704	740	777	1,517
GF	11	MNIT Post-payment IT staffing (50%FFP)	-	2,958	2,958	3,009	3,070	6,079
GF	11	Program Integrity Case Management Product Licensing Costs for Post-payment (50%FFP)	-	303	303	327	353	680
GF	11	Prof. Service & Staff Augmentation for machine learning fraud model implementation (50%FFP)	-	2,619	2,619	2,511	146	2,657
GF	11	Analytics and Case Management Software Licensing Costs for Post-Payment (50%FFP)	-	2,619	2,619	2,913	3,204	6,117

GF	33LW	MA Grants	-	(156,246)	(156,246)	(12,593)	(16,621)	(29,214)
GF	33ED	MA Grants	-	(13,330)	(13,330)	(1,092)	(1,456)	(2,548)
GF	33AD	MA Grants	-	(1,967)	(1,967)	(161)	(215)	(376)
GF	33FC	MA Grants	-	(15,629)	(15,629)	(1,280)	(1,707)	(2,987)

FTE Descriptions

Fund	BACT	Description	FY 26	FY 27	FY 25-27	FY 28	FY 29	FY 28-29
GF	11	Manager 17M	0	1	1	1	1	1
GF	11	MAPE 17L	0	1	1	1	1	1
GF	11	MAPE 14L	0	3	3	3	3	3
GF	11	MAPE 11L	0	3	3	3	3	3
GF	18	MAPE 11L	0	2	2	2	2	2
GF	18	MAPE 15L	0	2	2	2	2	2
GF	18	MAPE 17L	0	2	2	2	2	2
GF	18	MAPE 18L	0	2	2	2	2	2
GF	18	MAPE 20L	0	8	8	8	8	8
GF	18	Manager 17M	0	2	2	2	2	2
GF	18	Manager 19M	0	1	1	1	1	1
GF	18	MMA 24K	0	1	1	1	1	1
		Total		28	28	28	28	28

Impact on Children and Families:

Enhanced prepayment review does not have a significant impact on children and families. Expanding and enhancing prepayment review will support preventing fraud, waste, and abuse in fee-for-service Medicaid payments. While this may result in some claims being denied or suspended, the overall goal of the program is to ensure that improper payments are identified and stopped before funds are released and claims that meet proper adjudication processes are released within the regular warrant cycle.

Post-payment review and enhanced capabilities to review and respond to potential fraudulent payments complements prepayment review in DHS's continuing effort to ensure dollars are spent wisely and for their intended purpose. This work will ensure that children and families who are receiving services do not have excessive billing, duplicate payments or other improper practices submitted in their names. Ensuring accurate claims adjudication will allow children and families to maintain healthy lives through consistent coverage.

Equity and Inclusion:

A data-driven approach to program integrity facilitates a more equitable approach to program integrity controls. This proposal builds on best practices from public and private sectors to promptly detect and prevent improper payments before the funds are released, therefore increasing financial accountability and oversight to ensure that Minnesotans eligible for Medicaid receive consistent and accurate coverage of services.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

This proposal does not have a direct impact on Tribal governments.

Impacts to Counties:

There are no anticipated fiscal impacts to counties.

IT Costs:
Systems changes are required in MMIS, as well as the establishment of a vendor contract to develop an API between the prepayment vendor and MMIS. MNIT also requires additional staffing to support both enhanced prepayment and post-payment functions.

Category	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*	*FY 2030*	*FY 2031*
Payroll		$3,051,386	$610,277	$610,277	$610,277	$610,277
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)	0	$7,324,865	$7,496,851	$7,693,717	$6,998,432	$7,189,429
Total		$10,376,251	$8,107,128	$8,303,994	$7,608,709	$7,799,706
MNIT FTEs		24	24	24	21	21
Agency FTEs		28	28	28	28	28

Results:
The goal of this initiative is to enhance Medicaid payment integrity by transitioning to a proactive, data-driven approach that improves fraud, waste, and abuse detection, investigation efficiency, and oversight efficacy. The expected outcomes include optimized resource allocation for investigations and increased public trust in the integrity of publicly funded programs. Investing in enhanced Medicaid program integrity will likely result in cost savings obtained through increased monetary recoveries, cost avoidance, and deterrence due to increased prevention measures. Success will be measured over a three-year period, with initial improvements in case processing efficiency and fraud, waste, and abuse detection rates observable within the first twelve months of implementation. Once results are validated as effective based on the measures noted below, the systems and methodologies can be scaled for broader application of program integrity modernization in Minnesota's other public program types.

Measure	**Measure type**	**Measure data source**	**Most recent data**	**Projected change**
Briefly write what is being measured.	*Select quantity, quality, or result. Please try to include 1 of each.*	*Describe how the data for this measure will be collected.*	*If currently collected, provide most recent data for this measure. If not currently collected,*	*If successful, describe the change expected on this measure and to what extent.*

Measure	Measure type	Measure data source	Most recent data	Projected change
			please write N/A.	
Number of audits or investigations initiated through data-driven methods vs. tip-driven investigations	Quantity	Program Integrity Case Management System and the centralized data system created from this proposal	N/A	Shift to 50% proactive audits and investigations by Year 3
Average time from anomaly detection to case initiation for post-payment reviews.	Result	The centralized data system created from this proposal	N/A	Reduce average time from detection to case initiation to demonstrate operational efficiency and responsiveness

The qualitative measures will assess improvements in collaboration and user satisfaction with the new system:

- Stakeholder Feedback: Surveys and interviews with investigators, auditors, and program administrators will gauge the system's usability, collaboration effectiveness, and overall impact on workflow.
- Collection Method: Conduct semi-annual surveys and focus groups with key stakeholders.
- Expected Change: Feedback will reflect improved ease of use, transparency, and investigative efficiency.
- Narrative Case Studies: Highlight successful fraud investigations enabled by the new system to demonstrate impact.
    - Collection Method: Collect and analyze case studies annually from investigators using the new tools.
    - Expected Change: Case studies will illustrate how AI-driven insights identified fraud patterns that current methods of investigating within siloed systems missed.

By integrating quantitative and qualitative measures, this proposal will comprehensively evaluate the effectiveness of this legislative proposal in improving Medicaid integrity, optimizing investigative resources, and enhancing public trust.

Part B: Use of Evidence

While this proposal was informed through analysis of cost savings generated through current program integrity measures, none of the programs in this proposal have undergone a formal program evaluation. Due the reactionary nature of program integrity work at DHS, there is no formal evaluation planned at this time.

Department of Human Services
FY 2026-27 Biennial Budget Change Item

Change Item Title: Enhancing Program Integrity in Medical Assistance (IG-61)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	24,330	23,403	23,229
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	24,330	23,403	23,229
FTEs	**0**	**19**	**19**	**19**

Request:

The Governor recommends multiple strategies to strengthen program integrity in Minnesota's public health care programs (MHCP). This proposal includes the following strategies:

- Strengthening the provider enrollment process by establishing data-driven risk assessment pre-enrollment process for validating and approving eligible providers
- Enhance provider revalidation processes to more effectively meet federal program integrity requirements
- Strengthening the background studies requirements for high-risk providers
- Strengthening accountability requirements for Managed Care Organizations
- Funding for phase two of a thorough evaluation of the Department of Human Services to provide recommendations for restructuring the department's organizational structure and processes; and
- Clarifying allowable communication methods for withholding and recovering funds from enrolled providers

Rationale/Background:

Provider enrollment and screening processes

While MHCP has met federal requirements for provider screening and enrollment safeguards, the current processes and systems do not fully identify patterns of elevated risk—such as individuals who enroll multiple entities across programs or clusters of providers operating from the same high-risk or virtual locations. This proposal modernizes front-end controls to better align with national best practices for Medicaid program integrity. Additionally, this proposal aligns with Centers for Medicaid and Medicare (CMS) guidance on proactive fraud prevention, and federal Health and Human Services, Office of Inspector General recommendations for state Medicaid agencies to implement comprehensive risk-based screening.

Strengthening these checkpoints ensures providers who deliver services and receive public funds are more thoroughly screened, qualified and legitimate. Focusing on risk at the front-end of the process prevents fraudulent or unprepared entities from entering the system. This protects vulnerable Minnesotans and taxpayer funds. Changes are proposed to clarify and expand DHS's authority and integrate risk assessment into the provider enrollment process.

Strengthening provider revalidation processes to support program integrity

DHS currently requires high-risk provider revalidation to occur every three years. CMS may mandate off-cycle revalidation if they deem it necessary. This process also includes fingerprint background studies and an on-site

visit with the provider. DHS recently recategorized 14 service providers to high-risk and is required by CMS to revalidate these providers by the end of May 2026.

Currently, the Medicaid Payment and Provider Systems (MPPS) team within the Health Care Administration (HCA) at DHS sends providers initial letters to request information for revalidation and requests a response within 30 days. If providers do not respond within 30 days, MPPS sends a second letter reminding providers to send in their documentation and gives them an additional 30 days. If they still don't respond, we send the termination letter notifying providers that they will be disenrolled from the Medicaid program within 60 days unless they provide the requested information. DHS requires an adjustment to this revalidation timeline to support quicker revalidation processing in order to meet CMS mandates.

Background studies for high-risk providers

The background studies component of the proposal similarly focuses on risk at the front end of the hiring process. Background studies strengthen both program integrity and protections for individuals served by programs by determining whether a person has committed an act that would disqualify them from certain positions with the provider.

Program integrity accountability measures in Managed Care Organizations

Approximately 45% of Minnesota's Medical Assistance program spending is administered through Managed Care Organizations where the state contracts with a health plan, pays a set monthly capitation payment for each enrolled member, and the Managed Care Organization administers and pays the health care claims. As part of the contract, Managed Care Organizations are responsible for program integrity oversight and conducting procedures that effectively detect and prevent fraud, waste, and abuse.

Additional resources and requirements in state law are needed to enhance state oversight over the contractual program integrity responsibilities of Managed Care Organizations. The MCO Oversight team has 3 staff and 1 supervisor and focuses on auditing the MCOs for compliance and processing and coordinating FWA referrals to and from the MCOs. The Federal Audits and Investigations team within the Program Integrity Office (PIO) at DHS reviews some post-payment MCO claims with all Unified Program Integrity Contractor (UPIC) vendor cases. A more robust team and expanded review process would yield more recoveries.

This proposal updates state law to strengthen program integrity requirements for Managed Care Organizations participating in Minnesota Health Care Programs. This proposal also provides funding for a robust vendor solution to support post payment review for all managed care claims, and additional staff to enhance oversight within the PIO and the Managed Care Contracting and Rates Division that oversees managed care contracts, enforces breach of contracts, and monitors reporting and performance results from audits.

Comprehensive evaluation of DHS structure and processes

On September 17, 2025, Governor Tim Walz signed Executive Order 25-10 to empower state agencies to continue combatting fraud. As part of the executive order, section 1.g requires the Department of Human Services to "hire an external consultant to assess DHS and make recommendations on reorganization to more effectively serve as the state's Medicaid agency. The consultant's review should focus on program integrity and anti-fraud efforts, including suggested policies, procedures, system changes, organizational structure changes, staffing levels, and program integrity considerations that should be part of any state legislation that proposes to expand or create new covered Medicaid services. The consultant should also provide guidance how to best utilize partnerships with counties, Tribal Nations, and/or providers to minimize fraud and optimize efficient service delivery." In January 2026, the agency released a request for proposal and will execute a contract in early 2026.

This proposal provides funding for phase two of the project that will finalize recommendations that will enable the agency to increase program integrity, minimize fraud, and more effectively serve as the State's Medicaid agency.

Communication methods for withholding and recovering funds
Under current practice, claims seeking reimbursement for Medicaid services go through an adjudication process in the Medicaid Management Information System (MMIS). The process includes thousands of system edits that review information to ensure claims meet multiple requirements prior to funds being released. In the event that certain information is updated, such as an individual's eligibility status changes or a retroactive revision to Medicaid rates occurs, the system is automatically triggered to reprocess the claim. This also occurs when a claim includes incorrect or unallowable information, such as billing over a statutorily defined service limit. MMIS automatically conducts these reviews and reprocesses claims affected by changes such as this on a daily basis, which are implemented through system-coded thresholds and are reported out on a bi-weekly remittance advice report. This is a key upstream tool DHS utilizes to support program integrity within the Medicaid program.

There are instances where MMIS identifies errors in claims payment, such as claims seeking payment for a number of service units that exceeds policy limits established for that service and automatically seeks monetary recovery. This is a programmatic process that is reported out on the bi-weekly remittance advice report, which is electronically delivered to providers.

This proposal clarifies statute to explicitly allow the biweekly remittance advice report to serve as notice to providers for withholding and recovering funds at issue when MMIS is triggered to reprocess claims. This explicit authority codifies DHS' current practice to maintain program integrity controls using automatic systems. This portion of the request is budget neutral.

Proposal:

Enhancing provider enrollment and screening processes
This proposal strengthens provider enrollment and screening by more rigorously scrutinizing provider risk during the enrollment process. This proposal enhances the Department of Human Services' (DHS) authority to assess provider risk and readiness and confirm the legitimacy of provider entities through verified business information.

DHS will establish a structured, data-driven risk assessment. This assessment will evaluate organizational readiness, financial stability, compliance history, provider's business registration with the Secretary of State and service necessity. This proposal grants DHS authority under 256.01, subd. 2 and 256B.04, subd. 21, to apply the assessment to providers during the enrollment process in MHCP. The framework uses quantitative indicators like ownership history, business integrity, and the risk of a service type to assign risk tiers (low, moderate, high). This risk score will then guide enrollment decisions.

Strengthening provider revalidation processes to support program integrity
This proposal shortens the timeline in which providers have to respond to revalidation and potential termination of enrollment from 120 days now down to a total of 60 days. This proposal is budget neutral and would be effective upon enactment.

Strengthening background studies for high-risk providers
The background studies component of this proposal has three interrelated parts. First, it makes changes to 245C so that DHS has authority to conduct background studies for the following four high risk provider types: Adult Rehabilitative Mental Health Services (ARMHS), Peer Recovery, Adult Assertive Community Treatment (ACT), and Recuperative Care. Second, it invests in the systems development necessary to add those high-risk providers to NETStudy 2.0 so that DHS can conduct background studies for those providers. Third, it makes systems changes

necessary to implement the requirement that study subjects have an eligible or set aside determination prior to working for Community First Services and Supports (CFSS) providers. The needed changes are to NETStudy 2.0 functionality and to Adobe Experience Manager (AEM), the program used to generate notification letters for study subjects.

Strengthening program integrity accountability measures in Managed Care Organizations
This proposal strengthens program integrity in Managed Care. This proposal:

- Requires managed care organizations to conduct prepayment review of all claims
- Provides funding at DHS for an ongoing contract to perform post payment review of all MCO claims
- Requires MCO program integrity actions and outcomes to be publicly published, aligning with DHS's website on fee-for-service claims
- Requires MCOs to implement all claims edits and policies that are required for fee-for-service claims
- Additional staffing at DHS to enhance oversight over MCOs, including staff to monitor implementation of the above requirements, conduct audits, recover funds from MCOs, and conduct additional MCO oversight activities.

Funding a comprehensive evaluation of DHS structure and processes
This proposal provides $500,000 in fiscal year 2027 for phase two of the comprehensive evaluation of DHS's structure and processes. This one-time investment will fund final recommendations from an independent review that will enable the agency to increase program integrity, minimize fraud, and more effectively serve as the State's Medicaid agency.

Clarifying communication methods for withholding and recovering funds
This proposal also gives DHS the authority to use the biweekly remittance advice report as notice to a vendor or provider when seeking monetary recovery using MMIS for programmatically re-processed claims.

Fiscal Impact:

Pre-Enrollment Risk Assessment
The department will put out an RFP to find an appropriate vendor that is qualified to perform the services needed to carry out the design of the pre-enrollment risk assessment. This work includes conducting a one-time screening of all licensed and enrolled providers to generate an initial risk score that can help identify potential risks and guide decision making.

After an appropriate vendor is selected, the pre-enrollment process will be integrated into existing systems, including the provider hub. DHS will conduct automated provider risk assessments and produce risk scores for department review.

The increased workload of a pre-enrollment risk assessment process requires a small addition in FTEs for Medicaid Payment and Provider Systems (MPPS) and the Office of the Inspector General (OIG). OIG will need one 18L Data Analyst to review and utilize what is found by the department analyzing post-payment data to adjust our processes in provider risk assessments. MPPS will add one 14L HSP Rep 2 Systems Analyst and one 17L HSP Consultant to act as product manager. These staff will help with risk assessment requirements, develop the process, and finalize decisions regarding the automated risk assessment scores and how to proceed with providers who are flagged. They will also help with ongoing system updates related to maintenance and operations.

Strengthening background studies for high-risk providers
The background studies portion of the proposal includes two NETStudy 2.0 system change costs. The first set of costs will be one-time changes estimated at $31,000 for each of the four new high-risk provider types for a total

of $124,000. This investment will cover the design, development, testing, and deployment of each provider type into NETStudy 2.0, and the work will be completed by IA, the external vendor for the system. The second NETStudy 2.0 cost will be a one-time investment of $41,500 to implement the requirement that study subjects have an eligible or set aside determination prior to working for Community First Services and Supports (CFSS) providers. That work also will be completed by IA.

The new requirement for CFSS providers also requires updating notification letters for study subjects in AEM. This work will be completed by MNIT and cost a total of $11,082 for initial development and $2,216 ongoing. With a department anticipated FFP of 50% the MNIT costs amount to $5,500 for initial development and $1,100 ongoing costs.

Strengthening program integrity accountability measures in Managed Care Organizations
This proposal requests $30,000,000 to facilitate a competitive request for proposals (RFP) process for a vendor contract to enhance post-payment review of Managed Care Organizations claims. This contract would begin July 1, 2027. To support this work, the Program Integrity Oversight (PIO) division within the OIG and the Managed Care Contracting and Rates (MCCR) division within the Health Care Administration require additional staff.

To support implementation, operations and oversight of the vendor contract, PIO requires 12 new FTEs (1 Human Services Supervisor 4, 1 Human Services Supervisor 3, 6 MAPE 14L, 3 MAPE 17L and 1 MAPE 18L) to begin on July 1, 2027. These staff will provide oversight of the contract, support fund recovery from and negotiations with MCOs, and conduct additional oversight activities. The MAPE 18L will be a data analyst who will oversee MCO/PIO website integration and review to ensure oversight with MCO program integrity reporting to increase transparency of actions and outcomes for all Medicaid, including both managed care and fee-for-service (FFS).

MCCR requires 4 FTEs (4 MAPE 17L) that will conduct contract breach oversight, monitor and review MCO verification policies and procedures confirming enrollees received billed services, and coordinate between FFS and managed care to ensure all claims edits and policy limits are implemented by MCOs. These FTEs will also spot check MCO claims to ensure compliance.

Funding a comprehensive evaluation of DHS structure and processes
This proposal provides $500,000 in contract costs in fiscal year 2027.

Summary of Fiscal Impact:
Below are the net impacts of each component within this proposal:

Component (Dollars in thousands)	FY26/27	FY28/29
Pre-Enrollment Risk Assessment	1,246	1,870
Background Studies for High-Risk Providers	171	2
MCO Accountability	22,573	44,760
Phase II of DHS Evaluation	340	0
Clarifying communication methods for withholding and recovering funds	0	0

Fiscal Detail

Net Impact by Fund (Dollars in Thousands)	FY 26	FY 27	FY 26-27	FY 28	FY 29	FY 28-29
General Fund	0	24,330	24,330	23,403	23,229	46,632
Total All Funds		24,330	24,330	23,403	23,229	46,632

Fund	BACT	Description	FY 26	FY 27	FY 26-27	FY 28	FY 29	FY 28-29
GF	11	HCA Admin FTEs	0	304	304	358	358	716
GF	REV1	Admin FFP @ 71%	0	(216)	(216)	(254)	(254)	(508)
GF	18	OIG Admin FTE	0	161	161	191	191	382
GF	REV1	Admin FFP @ 32%	0	(51)	(51)	(61)	(61)	(122)
GF	11	Provider Hub Integration Fee	0	3	3	0	0	0
GF	11	Vendor Integration with Provider Hub Subscription Costs	0	204	204	214	225	439
GF	11	One-time Provider Batch (All licensing and PE)	0	189	189	0	0	0
GF	11	Integration with MPSE Subscription Costs	0	352	352	370	389	759
GF	11	Project Management & Process Improvement	0	200	200	204	0	204
GF	11	MPSE Integration	0	100	100	0	0	0
GF	11	OPS Admin – DHS Study contract costs	0	500	500	0	0	0
GF	REV1	Admin FFP @ 32%	0	(160)	(160)	0	0	0
GF	11	Including four high-risk providers in NetStudy 2.0 for background studies	0	124	124	0	0	0
GF	11	CFSS eligibility determination	0	41	41	0	0	0
GF	11	AEM changes for CFSS	0	6	6	1	1	2
GF	18	Vendor Contract - Post-payment review of Managed Care Organization billing	0	30,000	30,000	30,000	30,000	60,000
GF	REV1	Admin FFP @32%	0	(9,600)	(9,600)	(9,600)	(9,600)	(19,200)
GF	18	OIG Admin FTEs (MCO) (0, 12, 12, 12)	0	2,382	2,382	2,169	2,169	4,338
GF	REV1	Admin FFP @ 32%	0	(762)	(762)	(694)	(694)	(1388)
GF	13	HCA Admin FTEs (MCO) (0, 4, 4, 4)	0	813	813	742	742	1484
GF	11	Admin FFP @ 32%	0	(260)	(260)	(237)	(237)	(474)

Requested FTEs

Fund	BACT	Description	FY 26	FY 27	FY 26-27	FY 28	FY 29	FY 28-29
GF	11	MAPE 14L HSP Rep. 2	0	1	1	1	1	1
GF	11	MAPE 17L HSP Consultant	0	1	1	1	1	1
GF	18	MAPE 18L Data Analyst	0	1	1	1	1	1
GF	13	MAPE 17L HSP Consultant	0	4	4	4	4	4
GF	18	15M - Human Services Manager 1	0	1	1	1	1	1
GF	18	MMA 21K - Human Services Supervisor 3	0	1	1	1	1	1
GF	18	MAPE 14L - Human Services Program Rep. 2	0	6	6	6	6	6
GF	18	MAPE 17L - Human services program consultant level	0	3	3	3	3	3
GF	18	MAPE 18L - Data Analyst	0	1	1	1	1	1

Impact on Children and Families:

For children, youth, and families, stronger provider enrollment safeguards directly support the administration's priorities. By preventing fraudulent or unqualified providers from entering Medicaid programs, the proposals help ensure that vulnerable families receive services from safe, reliable, and competent providers. This protects access to high-quality care in areas such as early childhood supports, mental health services, home- and community-based care, and housing stabilization. Safeguarding taxpayer resources also strengthens the sustainability of programs that promote a healthy start, stable housing, and comprehensive supports for families.

Equity and Inclusion:
These proposals are intended to reduce inequities for communities that are disproportionately affected by fraud, waste, and abuse in Medicaid programs, including people of color, Native Americans, people with disabilities, LGBTQ Minnesotans, and Veterans. Because these groups are overrepresented among Medicaid recipients, they are especially vulnerable when unqualified or fraudulent providers enter the system. Strengthening provider enrollment safeguards ensures that public resources are directed toward legitimate, competent providers, which in turn protects access to safe and reliable care for these communities.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

There are no anticipated substantial impacts on Minnesota's Tribal governments.

Impacts to Counties:
There are no anticipated financial impacts to counties.

IT Costs:
This proposal includes the following IT costs:

Category	***FY 2026***	***FY 2027***	***FY 2028***	***FY 2029***	***FY 2030***	***FY 2031***
Payroll						
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software (AEM updates)	0	$11,298	$2,260	$2,260	$2,260	$2,260
Training						
Enterprise Services						
Staff costs (MNIT or agency)						
Total						
MNIT FTEs						
Agency FTEs						

Results:

Part A: Performance Measures

1. The goal of these proposals is to strengthen program integrity in Medicaid provider enrollment by preventing fraudulent applications, ensuring organizational readiness before enrollment, and requiring active business filings with the Secretary of State. The expected outcomes are a reduction in fraudulent or unqualified providers entering the Medicaid system, improved accountability and transparency in provider vetting, and stronger safeguards for vulnerable populations who rely on these services.
2. More stringent requirements on the front end of provider enrollment efforts are known to reduce fraudulent and wasteful provider payments that must be recouped through legal actions on the backend.
3. The department will monitor rejected providers at enrollment to track how effective these measures are at weeding out unreliable providers.
4. With enhanced MCO accountability through a post-payment vendor review contract and a larger PIO review staff, there will be increased recoveries from MCOs following a more robust and expansive post-payment review process.

Measure	**Measure type**	**Measure data source**	**Most recent data**	**Projected change**
Increase number of providers maintaining Secretary of State filing.	*Total numbers in compliance.*	*Review of providers prior to enrollment.*	*N/A*	*Every provider going forward will maintain active business filing.*
Prevented enrollment after incomplete or inaccurate application.	Reduction in providers previously denied enrollment.	A reduction in repeat fraudulent applicants.	N/A	Reduction in misappropriated dollars.
Reduction in troubled, fraudulent, or unreliable providers from enrolling.	Reduction in actions taken to recover funds.	Fewer actions to recover misappropriated money.	N/A	There should be savings for DHS when fewer unprepared or fraudulent providers make it to enrollment.
Increase in recoveries from MCO providers	More revenue recovered through a larger sustained review effort	More monetary recoveries than in previous years.	N/A	There should be more post-payment recoveries with a more robust system of post-payment review.

Part B: Use of Evidence

1. Have you previously conducted a formal quantitative or qualitative program evaluation that informed the contents of this proposal? If so, please briefly describe the evaluation. We are currently conducting an independent evaluation of DHS structure and processes. This proposal funds phase 2 of that evaluation.
2. Are you planning to conduct a formal qualitative or quantitative program evaluation related to this proposal? Indicate what kind(s) of evaluation you will be conducting. Select all that apply.

__ No formal evaluation planned at this time
_X_ Not yet determined
__ Needs Assessment
__ Process or Implementation Evaluation
__ Summative Impact Evaluation (Randomized Control Trial (RCT) or Quasi-Experimental Design)
__ Summative Evaluation other than an Impact Evaluation
__ Other (please describe or link):

Statutory Change(s):
256.01 subd. 2; 256B.04, subd. 21 – Enhancing program integrity in medical assistance
256B.0645 - Recoveries

Change Item Title: Billing and Payment Oversight for Disability, Older Adult, and Behavioral Health Services (AD-68)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures		(10,568)	(114,645)	(167,490)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)		(10,568)	(114,645)	(167,490)
FTEs	**0**	**10.5**	**15.5**	**16**

Request:

The Governor proposes multiple strategies to provide comprehensive improvements to the billing and oversight functions of disability, older adult, and behavioral health services. This proposal will result in greater oversight in billing practices, will increase accountability for providers seeking reimbursement from the state and federal government, and will ensure that payments reflect services rendered.

This proposal includes the following components to increase program integrity in payments and billing:

- HCBS Provider Accountability through Support Plan Documents
- Enhanced State Monitoring and Oversight of Service Delivery
- Enhanced Staffing Documentation in Residential Services
- DWRS Staffing Billing Requirements
- Expanding Electronic Visit Verification
- Customized Living Acuity-based Aggregate Billing Caps under Disability Waivers
- Community Residential Services (CRS) Acuity-based Limits under Disability Waivers
- Adding and Modifying Billing Limits
- Elimination of remote service provision
- Expedited Sunset of the Disproportionate Share Program

Rationale/Background:

Residential Services under the Disability Waivers: Aligning Payments with Level of Service Provided

Disability waiver service rates are developed by the person's case manager or care coordinator, using the electronic MnCHOICES Support Plan application. The support planning process is based on the person's assessed needs, goals, and preferences. The case manager works with the person to determine how their needs will be met, including what needs will be met by a residential services provider. For residential services including customized living, foster care, community residential services, and integrated community supports, the daily rate for the provider is determined based on the number of hours of staffing necessary to meet the needs identified in the support plan on an average day. Depending on the service, the rate may include an assumption about on-site staff availability.

Rates for residential services under the waivers are based on average daily or weekly (depending on rate framework requirements) planned staffing. A daily rate is an effective and appropriate way to pay for residential

HCBS services, with the appropriate monitoring and safeguards in place. This includes ensuring that participants receive the services outlined in their support plan. A daily rate can encompass services delivered by various types of professionals within the setting. It can also account for natural fluctuations in a person's needs from day to day.

There currently is no minimum level of compliance with delivery of planned staffing in state law or in our federally approved waiver plan. There is no current mechanism for obtaining staffing or service delivery information from residential providers. Current state law requires providers who provide at least one service with rates determined by Disability Waiver Rate System (DWRS) submit a cost report of the actual cost to provide the service, however, this is aggregate, organizational-level data which limits DHS's ability to verify costs reported to specific service sites or people. DHS uses cost report data gathered to make evidence-based recommendations to the Legislature about the payment rates for disability waiver services.

Establishing or Modifying Billing Limits
DHS conducted a comprehensive review of service delivery and billing limits for HCBS and behavioral health services and identified opportunities to modify or add billing limits. Limits will ensure that services are being delivered in alignment with original program intent, while enhancing program integrity. This proposal offers solutions to implement new monitoring and safeguards for these services.

Electronic Visit Verification
Electronic Visit Verification (EVV) is utilized by the state to document that people are receiving the services that are billed to the state. Minnesota began implementing EVV in 2022 for the personal care assistance (PCA) program and some waiver services.

EVV documents:

- The type of service performed
- Who received the service
- Date of service
- Location of service delivery
- Who provided the service
- When the service begins and ends.

Currently, EVV is required for a limited number of services. This proposal expands this requirement to additional services in the HCBS and behavioral health service continuum.

Elimination of Remote Service Provision
Remote services were added to some waiver and AC services after the COVID pandemic. Remote supports are no longer needed for five services because they have on-site staff that can continue to provide in-person supports in lieu of remote supports.

Ending Disproportionate Share Program to Ensure Payments Reflect Services Rendered
The Disproportionate Share Program provides a Customized Living rate floor for Elderly Waiver (EW) residents of eligible facilities who serve a high proportion of waiver participants. The rate floor increases payment rates for people with lower service needs beyond the services rendered to them. This program was set to sunset on December 31, 2026, however the 2025 legislature extended this to May 2028. This proposal will end the Disproportionate Share Program as of January 1, 2027, to align with the original legislative intent and to ensure that payments reflect services rendered.

Proposal:

This proposal includes the following components to increase program integrity in payments and billing:

- HCBS Provider Accountability through Support Plan Documents
- Enhanced State Monitoring and Oversight of Service Delivery
- Enhanced Staffing Documentation in Residential Services
- DWRS Staffing Billing Requirements
- Expanding Electronic Visit Verification
- Customized Living Acuity-based Aggregate Limits under Disability Waivers
- Community Residential Services (CRS) Acuity-based Limits under Disability Waivers
- Adding and Modifying Billing Limits
- Elimination of remote service provision
- Expedited Sunset of the Disproportionate Share Program

HCBS Provider Accountability through Support Plan Documents

This proposal will provide role-based access to the MnCHOICES support plan system to providers that allows providers to only access support plan where they have been designated as a provider for that person. Providers would be able to sign the person's support plan electronically, demonstrating that they reviewed, understood, and agreed to deliver services as outlined in the plan. Providers would not be able to access the person's assessment or any other information that was not necessary for them to deliver services.

Currently, providers cannot access the support plan via the MnCHOICES system. Case managers and care coordinators must provide the support plan outside the MnCHOICES system (i.e. encrypted emails, faxes), and providers must return a signed copy through the same mechanism. This proposal will create an electronic record and enhance accountability.

Enhanced Monitoring and Oversight of Service Delivery

This proposal implements additional monitoring and oversight of service delivery at the state level, to enhance the monitoring and oversight provided by case managers. Case managers are responsible for ensuring that providers deliver services as written in the support plan. They do this through check-ins with the person and provider. When they become aware of issues, they advocate for the person and can remind providers of their responsibilities. They can update the person's plan and the provider's rate if the person's needs change. They can assist the person to transition to a new provider if the current situation does not meet the person's needs. However, case managers lack the ability to hold providers accountable through payment suspensions or other sanctions if the provider is consistently not delivering services as outlined in the plan.

This proposal gives DHS the authority to request service delivery documentation directly from providers. DHS will then compare the documentation to the person's MnCHOICES support plan to ensure that service delivery is aligned with the plan. If service delivery is not aligned with the plan, this proposal gives DHS the authority to suspend provider payments while DHS works with the provider, case manager, and the person receiving services on a remediation plan.

Enhanced Staffing Documentation in Residential Services

This proposal requires HCBS waiver residential providers to maintain staffing documentation on an ongoing basis to reflect actual staffing and services provided. It also requires providers to provide staffing documentation when requested by lead agencies or DHS to verify staffing levels provided align with staffing levels authorized.

DWRS Staffing Billing Requirements

This proposal establishes billing rules that require actual staffing and service delivery provided to the person to be within 90% of the planned staffing level that the DWRS rate is based on. When actual staffing is less than 90% of

planned staffing, the provider's billing rate would be reduced by the difference between actual staffing and the 90% target. For example, if actual staffing delivered is 85% of planned, the provider rate would be reduced 5%.

Expanding Electronic Visit Verification
This proposal requires providers to use an electronic visit verification (EVV) system to document service delivery, allowing DHS to analyze whether service delivery is aligned with the person's support plan and that claims submitted by the provider are aligned with services rendered.

EVV will be required for the following additional services:

- Adult Rehabilitative Mental Health Services (ARMHS)
- Peer Support Services
- Community Residential Services (CRS)
- Assertive Community Treatment (ACT)
- Early Intensive Developmental and Behavioral Intervention (EIDBI)
- Customized Living (CL)
- Family Residential Services (FRS)
- Adult Foster Care
- Adult Companion Services
- Adult Day Services
- Homemaker Services
- Waiver Transportation
- Non-emergency medical transportation (NEMT)
- Children's Therapeutic Services and Supports (CTSS)

Implementation of EVV is expected to reduce service costs for impacted services. In addition to this programmatic impact, this proposal includes systems costs for implementing EVV. In another governor's budget proposal, Enhancing Program Integrity in Integrated Community Supports (ICS), EVV is also proposed to be required for ICS. The systems costs in this proposal include the costs for that expansion.

Customized Living Acuity-based Aggregate Billing Caps under Disability Waivers
This proposal aligns customized living billing under disability waivers with current provisions for the Elderly Waiver regarding aggregate monthly service rate limits. Currently, the Elderly Waiver customized living monthly service rate limit is established by case mix classification budget cap and is adjusted annually. For 24-hour Elderly Waiver customized living, this monthly service rate limit is based on statewide percentiles and adjusted annually. Under this proposal, these service rate limits would apply to customized living for disability waiver recipients as well.

Community Residential Services (CRS) Acuity-based Limits under Disability Waivers
This proposal places an hour input limit on Community Residential Services based on the capacity of the provider location. Additionally, for individuals where they do not need awake overnight supervision, there will be limits based on case mix listed below. An exceptions process will be developed to allow exceptions with documentation, however there would be no exceptions for individuals with case mix A or C (or the developmental disability case mix equivalent.

Case Mix Type	Hour Limit
A, C, L	2 hours
B, D, F	8 hours
E, G, I, J , K	16 hours
H	24 hours

Adding and Modifying Billing Limits

HCBS Service Billing Limits

This proposal establishes or modifies billing limits for various HCBS services. These changes will ensure that delivery of service aligns with best practices and will restrict outliers in excessive billing or use of service beyond intention. This proposal will enhance program integrity by verifying that providers are billing for proper service usage and that service delivery aligns with the needs of recipients.

The table below outlines the proposed limits and impacts of each service:

Service Title	Proposed Limit
Adult Companion Services	6 hours daily, 936 hours annually
Assistive Technology	Annual $10,000
Chore Services	6 hours per week for 15-minute units
Day support services	8 hours per day
EIDBI Intensive services	40 hours per week
EIDBI Travel	2 hours per day
EIDBI Observation and Direction	20 hours per week
EIDBI Individual Treatment and Planning	300 units/year
Family Training	2 hours per week
Homemaking services	16 hours per week
Individualized Home Supports (IHS)	16 hours per day
Independent Living Skills (ILS)	6 hours per day
Night Supervision	10 hours per day, with no more than 8 hours asleep
Personal Emergency Response System (PERS)	1 payment per month
Respite – In Home	30-day consecutive limit
Waiver Transportation services	28 one-way trips per week, development of one-way trip rate framework

This proposal also provides administrative and systems resources for development of exceptions guidelines and process for individuals with exceptional needs.

Behavioral Health Services Billing Limits

This proposal also establishes or modifies billing limits and authorization requirements for several behavioral health services to promote appropriate utilization and program integrity. Proposed limits are as follows:

Service Title	Proposed Limit
Adult Rehabilitative Mental Health Services (ARMHS)	Require prior authorization for services exceeding 200 hours per person per year. Establish a weekly limit of 4 hours and a monthly limit of 18 hours, unless prior authorization is obtained.
Intensive Residential Treatment Services (IRTS)	Require authorization for stays beyond 30 days. This allows timely access, particularly when stepping down from inpatient hospitalization, while ensuring ongoing oversight. Reduce the standard service limit from 90 days to 30 days to ensure continued compliance with medical necessity.
CTSS Skills Training	Limit to no more than 2 hours per day, no more than 3 days per week. Retain the current 200-hour annual aggregate limit.
CTSS – Mental Health Behavioral Aide	Limit to no more than 6 hours per day, no more than 3 days per week. Retain the current 200-hour annual aggregate limit.

Service Title	Proposed Limit
Psychoeducation/Skills (Outpatient)	Limit to no more than 2 hours per day, no more than 3 days per week.
Treatment Coordination	Limit to no more than 5 hours per week.
Peer Services	Limit to no more than 10 hours per week. Limit to in-person services only. No transportation.

Elimination of Remote Services

This proposal eliminates the ability for certain provider-controlled home and community-based services to be delivered remotely. The bill repeals statutory authorization for remote overnight supervision in a community residential setting and directs the commissioner to seek federal approval to remove remote support as an allowable method of service delivery for the following provider-controlled waiver services:

1. Adult Day Service
2. Community residential services
3. Day support services
4. Family residential services
5. Integrated community supports

Expedited Sunset of the Disproportionate Share Program

This proposal ends the Disproportionate Share Program effective January 1, 2027 rather than the current extended date of May 2028. The Disproportionate Share Program (DSP) provides a Customized Living (CL) rate floor for Elderly Waiver (EW) residents of eligible facilities who serve a high proportion of waiver participants. This proposal ensures that customized service rates reflect a person's needs and the services rendered to them.

Fiscal Impact

In addition to programmatic impacts, this proposal requires admin costs for a new team within the Aging and Disability Services Administration to provide quality monitoring and enforce new billing rules outlined in this proposal. This proposal also includes systems costs to give providers access to the MnCHOICES support plan and to expand EVV.

Below is the fiscal impact by component:

Net Impact by Component (in thousands)	FY27	FY28	FY29
HCBS Provider Support Plan Accountability	617	640	680
Enhanced State Monitoring and Oversight of Service Delivery, Enhanced Staffing Documentation in Residential Services, & DWRS Staffing Billing Requirements	1,968	1,324	1,324
Expanding Electronic Visit Verification	324	(3,405)	(3,812)
Customized Living Acuity-Based Limits	(10,022)	(99,530)	(133,126)
Community Residential Services Acuity-Based Limits	0	(2,234)	(22,888)
Adding and Modifying Billing Limits	(2,605)	(9,231)	(9,669)
Elimination of Remote Service Provision	0	0	0
Expedited Sunset of the Disproportionate Share Program	(849)	(2,209)	0

Fiscal Tracking:

Net Impact by Fund (dollars in thousands)			FY 26	FY 27	FY 26-27	FY 28	FY 29	FY 28-29
General Fund			-	(10,568)	(10,568)	(114,645)	(167,490)	(282,135)
HCAF								
Federal TANF								
Other Fund								
Total All Funds			-	(10,568)	(10,568)	(114,645)	(167,490)	(282,135)
Fund	**BACT#**	**Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	11	Systems- ARS (Role Based Access to MnCHOICES)	-	337	337	-	-	-
GF	11	Systems - SSAM (Role Based Access to MnCHOICES)	-	67	67	67	67	134
GF	11	Systems- MnCHOICES FEI (Role Based Access to MnCHOICES)	-	213	213	360	360	720
GF	14	MnCHOICES Provider SMEs - FARM (0, 0, 1.5, 2)	-	-	-	313	371	684
GF	REV1	Admin/Contract FFP @32% (MnCHOICES Provider SMEs - FARM)	-	-	-	(100)	(118)	(218)
GF	11	Systems- Agile Apps (Service Delivery Oversight and Staffing)	-	968	968	194	194	388
GF	11	SFTP Systems- Application Support (Service Delivery Oversight and Staffing)	-	51	51	10	10	20
GF	14	FARM QM FTEs (0, 6.75, 9, 9) - (Service Delivery Oversight and Staffing)	-	1,395	1,395	1,647	1,647	3,294
GF	REV1	Admin/Contract FFP @32% - (Service Delivery Oversight and Staffing)	-	(446)	(446)	(527)	(527)	(1,054)
GF	33	MA LW Disability Waivers FFS (EVV)	-	(240)	(240)	(613)	(672)	(1,285)
GF	33	MA LW Elderly Waiver FFS (10%) (EVV)	-	(41)	(41)	(106)	(115)	(221)
GF	33	MA ED Elderly Waiver MC (90%) (EVV)	-	(365)	(365)	(950)	(1,033)	(1,983)
GF	34	MA LW AC/ECS (EVV)	-	(17)	(17)	(47)	(52)	(99)
GF	11	Systems (MMIS and EVV Vendor) (EVV)	-	1,349	1,349	497	497	994
GF	33	MA FC (EIDBI EVV Reduction)	-	-	-	(852)	(958)	(1,810)
GF	33	MA ED (EIDBI EVV Reduction)	-	-	-	(869)	(977)	(1,846)
GF	33	MA LW FFS (Night Supervision Billing Limit)	-	(181)	(181)	(1,705)	(2,250)	(3,955)
GF	11	Systems MMIS (Night Supervision Billing Limit)	-	38	38	8	8	16
GF	14	ADSA LAR Admin (0,0.75,1,1) - (Night Supervision Billing Limit)	-	138	138	160	160	320
GF	REV1	Admin/Contract FFP @32% (Night Supervision Billing Limit)	-	(44)	(44)	(51)	(51)	(102)
GF	33	MA LW Elderly Waiver FFS (End DSP Early)	-	(85)	(85)	(221)	-	(221)
GF	33	MA ED Elderly Waiver MC (End DSP Early)	-	(764)	(764)	(1,988)	-	(1,988)
GF	33	MA LW - Elderly Waiver FFS (Adult Companion Billing Limit)	-	(1)	(1)	(3)	(3)	(6)
GF	33	MA ED - Elderly Waiver MC (Adult Companion Billing Limit)	-	(10)	(10)	(26)	(28)	(54)

GF	34	MA LW - Alternative Care FFS (Adult Companion Billing Limit)	-	(1)	(1)	(2)	(2)	(4)
GF	33	MA LW FFS (Assistive Technology Billing Limit)	-	(9)	(9)	(93)	(123)	(216)
GF	33	MA LW FFS (Chore Billing Limits)	-	(276)	(276)	(705)	(773)	(1,478)
GF	33	MA ED MC (Chore Billing Limits)	-	(64)	(64)	(167)	(181)	(348)
GF	34	AC/ECS (Chore Billing Limits)	-	(40)	(40)	(109)	(123)	(232)
GF	33	MA LW FFS (CRS acuity)	-	-	-	(2,265)	(22,888)	(25,153)
GF	11	State share of MnCHOICES (75% FFP) (CRS acuity)	-	-	-	31	-	31
GF	33	MA LW FFS (Day Support Billing Limit)	-	(3)	(3)	(8)	(9)	(17)
GF	33	MA FC (EIDBI Intensive Billing Limit)	-	(91)	(91)	(222)	(229)	(451)
GF	33	MA ED (EIDBI Intensive Billing Limit)	-	(92)	(92)	(226)	(233)	(459)
GF	14	ADSA FTE (0,0.75,1,) (EIDBI Intensive Billing Limit)	-	147	147	172	172	344
GF	REV1	Admin FFP @ 32% (EIDBI Intensive Billing Limit)	-	(47)	(47)	(55)	(55)	(110)
GF	33	MA FC (EIDBI Travel Billing Limit)	-	(2)	(2)	(6)	(6)	(12)
GF	33	MA ED (EIDBI Travel Billing Limit)	-	(2)	(2)	(6)	(6)	(12)
GF	33	MA FC (EIDBI Observation Direction Billing Limit)	-	(203)	(203)	(498)	(513)	(1,011)
GF	33	MA ED (EIDBI Observation Direction Billing Limit)	-	(207)	(207)	(507)	(522)	(1,029)
GF	33	MA FC (EIDBI ITP Billing Limit)	-	(378)	(378)	(927)	(955)	(1,882)
GF	33	MA ED (EIDBI ITP Billing Limit)	-	(385)	(385)	(944)	(972)	(1,916)
GF	33	MA LW FFS (Family Training Billing Limit)	-	(130)	(130)	(332)	(363)	(695)
GF	33	MA LW (Homemaking Billing Limit)	-	(801)	(801)	(2,049)	(2,245)	(4,294)
GF	33	MA LW EW FFS (10%) (Homemaking Billing Limit)	-	(12)	(12)	(32)	(35)	(67)
GF	33	MA ED EW MC (90%) (Homemaking Billing Limit)	-	(111)	(111)	(289)	(313)	(602)
GF	34	AC (Homemaking Billing Limit)	-	(96)	(96)	(259)	(292)	(551)
GF	33	MA LW FFS (IHS Billing Limit)	-	(43)	(43)	(109)	(119)	(228)
GF	33	MA LW FFS (ILS Billing Limit)	-	(3)	(3)	(7)	(7)	(14)
GF	33	MA LW (PERS Billing Limit)	-	(14)	(14)	(37)	(40)	(77)
GF	34	AC (PERS Billing Limit)	-	(1)	(1)	(3)	(3)	(6)
GF	33	MA LW EW FFS (10%) (PERS Billing Limit)	-	(5)	(5)	(12)	(13)	(25)
GF	33	MA ED EW MC (90%) (PERS Billing Limit)	-	(41)	(41)	(106)	(116)	(222)
GF	33	MA LW FFS (Respite Billing Limit)	-	(38)	(38)	(97)	(106)	(203)

GF	33	MA LW FFS (Transportation Billing Limit)	-	(235)	(235)	(599)	(656)	(1,255)
GF	33	MA ED MC (Transportation Billing Limit)	-	(17)	(17)	(43)	(48)	(91)
GF	34	AC (Transportation Billing Limit)	-	(1)	(1)	(4)	(4)	(8)
GF	11	Systems MMIS (Transportation Billing Limit)	-	5	5	1	1	2
GF	11	Systems MnCHOICES (Transportation Billing Limit)	-	13	13	-	-	-
GF	14	ADSA FTE (0,1.5,2,2) - Transportation SMEs (Transportation Billing Limit)	-	294	294	344	344	688
GF	REV1	Admin FFP (Transportation Billing Limit)	-	(94)	(94)	(110)	(110)	(220)
GF	14	Exceptions Vendor Start-up Cost	-	150	150	150	-	150
GF	14	Exceptions Vendor Maintenance Costs	-	-	-	1,200	2,472	3,672
GF	REV1	Admin FFP @ 32% Exceptions vendor	-	(48)	(48)	(432)	(791)	(1,223)
GF	14	ADSA FTE - Contract manager and Policy Exceptions SME (0,0.75,1,1)	-	147	147	172	172	344
GF	REV1	Admin FFP @ 32% Contract	-	(47)	(47)	(55)	(55)	(110)
GF	11	MMIS State share @ 29%	-	73	73	15	15	30
GF	33	MA AD - ARMHS, IRTS, CTSS Billing Limit: : 1/1/2027	-	(16)	(16)	(55)	(62)	(117)
GF	33	MA ED - ARMHS, IRTS, CTSS Billing Limit: : 1/1/2027	-	(291)	(291)	(903)	(935)	(1,838)
GF	33	MA FC - ARMHS, IRTS, CTSS Billing Limit:: 1/1/2027	-	(39)	(39)	(122)	(127)	(249)
GF	35	BHF - Treatment Coordination, Peer Services Billing Limit: : 1/1/2027	-	(17)	(17)	(43)	(43)	(86)
GF	11	System MMIS @ 29% - ARHMS, IRTS, CTSS Billing Limit	-	25	25	5	5	10
GF	33	MA - ARMHS, Peer Services, ACT - EVV Savings: 1/1/2027	-	(604)	(604)	(1,227)	(1,264)	(2,491)
GF	13	ARMHS, IRTS, CTSS Billing Limit: HCA Authorization Contract	-	500	500	500	500	1,000
GF	11	EVV Vendor Costs: ARMHS, Peer Services, ACT	-	31	31	118	118	236
GF	33	MA FFS	-	(10,022)	(10,022)	(99,938)	(133,966)	(233,904)
GF	14	Exceptions Vendor Costs	-	-	-	600	1,236	1,836
GF	REV1	Admin FFP @ 32%	-	-	-	(192)	(396)	(588)
GF	11	EVV Vendor Costs: HCA: NEMT	-	211	211	644	644	1,288
Fund	**BACT#**	**FTEs Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	14	MnCHOICES Provider SMEs - FARM (0, 0, 1.5, 2)	0	0		1.5	2	
GF	14	FARM QM FTEs (0, 6.75, 9, 9) - (Service Delivery Oversight and Staffing)	0	6.75		9	9	
GF	14	ADSA LAR Admin (0,0.75,1,1) - (Night Supervision Billing Limit)	0	0.75		1	1	
GF	14	ADSA FTE (0,0.75,1,) (EIDBI Intensive Billing Limit)	0	0.75		1	1	

GF	14	ADSA FTE (0,1.5,2,2) - Transportation SMEs (Transportation Billing Limit)	0	1.5		2	2	
GF	14	ADSA FTE - Contract manager and Policy Exceptions SME (0,0.75,1,1)	0	0.75		1	1	

Impact on Children and Families:
This proposal impacts recipients of HCBS and behavioral health services through limitations on units available for billing. Further, proper delivery of necessary services and integrity in billing will ensure that programs operate efficiently and that taxpayer funds are used properly for the individuals who receive services.

Equity and Inclusion:
This proposal will impact people who receive various residential services in our HCBS waiver programs. Demographics of those participants can be found here: LTSS demographic dashboard / Minnesota Department of Human Services.

This proposal will impact people who receive various residential or HCBS waiver services through DHS. According to the publicly available LTSS Demographic Dashboard, the population served by LTSS and HCBS in Minnesota is substantially more diverse than the general state population in several respects. LTSS demographic dashboard / Minnesota Department of Human Services.

As of the most recent LTSS report, among people receiving LTSS services statewide, approximately 39.5% identify as Black, Indigenous, or People of Color (BIPOC) — compared to a much higher proportion of white individuals in the general population. Because the population served by HCBS and LTSS is more racially and ethnically diverse than the general population — and includes many people with disabilities, younger adults, and people who rely on public supports — the changes proposed (billing limits, staffing documentation, EVV, ending of DSP, etc.) could have disproportionate impacts on BIPOC individuals, people with disabilities, and younger or working-age adults on waiver services. The intended changes also, however, are intended to ensure that people receive the supports that are planned for in their support plan.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

This proposal will impact Tribal Nations who serve as lead agencies, as well as Nations that are delivering HCBS services in the process of authorizing and monitoring service delivery.

Impacts to Counties:
This proposal will impact counties, who serve as lead agencies and provide HCBS waiver case management, or contract with case management companies to provide case management. This proposal provides some additional support to case managers to address quality concerns with HCBS providers.

IT Costs
There are several IT components to this proposal including:

1. Providing access to MnChoices Support Plan: Estimated duration 3 years
2. Creates a new application for team to collect and review staffing documentation: Estimated duration 4 years
3. Updates EVV vendor extract file and provides funds to EVV Vendor

4. Updates billing edits for night supervision and BHA
5. Provides access to vendor for billing limits
6. Updates various frameworks (CRS, Transportation) in MNChoices

Category	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Payroll				
Professional/Technical Contracts	0	3,297	4,210	4,179
Infrastructure				
Hardware				
Software				
Training				
Enterprise Services				
Staff costs (MNIT or agency)	0	1,592	305	305
Total	0	4,889	4,515	4,484
MNIT FTEs				
Agency FTEs				

Results:

Part A: Performance Measures

Overall Goal and Expected Outcomes
The primary goal is to ensure that Minnesota's Medicaid expenditures for disability, older adult, and behavioral health services accurately reflect the actual hours of care provided to recipients. We expect this change item to be successful if, by the end of FY 2029, aggregate billing aligns within a 10% variance of authorized support plans and Electronic Visit Verification (EVV) data.

Evidence of Effectiveness
The transition to EVV for PCA services in 2022 serves as a primary internal benchmark; preliminary data suggests that real-time verification reduces billing errors and over-reporting. Furthermore, the 2024 DHS cost report data identified significant "staffing gaps" where actual site-level delivery did not match aggregate reporting. By implementing role-based access to MnCHOICES and acuity-based limits, DHS is applying a proven "utilization management" framework used in private-sector managed care to public HCBS waivers.

Quantitative Measures

Measure	Measure Type	Measure Data Source	Most Recent Data	Projected Change
Staffing Compliance Rate: Percentage of residential providers whose actual staffing is within 90% of the authorized support plan.	Quality	DHS Quality Monitoring (QM) Audits and Payroll Documentation	Baseline to be established in FY 26	85% compliance by end of FY 28
Cost Avoidance: Reduction in General Fund expenditures through acuity-based billing caps and limits.	Result	MMIS (Medicaid Management Information System) Financial Reports	N/A (New limits)	$282.1 Million total savings through FY 29

EVV Utilization: Number of newly added service categories (e.g., ARMHS, EIDBI) successfully submitting claims through EVV.	Quantity	EVV Vendor Portal / HHAeXchange Data	0 (New services)	14 additional service categories fully integrated by FY 28

Part B: Use of Evidence

3. Have you previously conducted a formal quantitative or qualitative program evaluation that informed the contents of this proposal? If so, please briefly describe the evaluation. Response: No
4. Are you planning to conduct a formal qualitative or quantitative program evaluation related to this proposal? Indicate what kind(s) of evaluation you will be conducting. Select all that apply.

   _x_ No formal evaluation planned at this time
   __ Not yet determined
   __ Needs Assessment
   __ Process or Implementation Evaluation
   __ Summative Impact Evaluation (Randomized Control Trial (RCT) or Quasi-Experimental Design)
   __ Summative Evaluation other than an Impact Evaluation
   __ Other (please describe or link):

Department of Human Services

FY 2026-27 Biennial Budget Change Item

Change Item Title: Enhancing Program Integrity in Integrated Community Supports Services (AD-59)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	2,387	(554)	(3,390)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	2,387	(554)	(3,390)
FTEs	**0**	**0.75**	**1**	**1**

Request:

The Governor proposes a package of reforms to strengthen oversight of Integrated Community Supports (ICS). These reforms are intended to ensure services are delivered as authorized, rates are aligned with service delivery, funding streams for housing and waiver services are distinct, and there is a sustainable provider network to meet the needs of people. These reforms will ensure services accurately reflect individual needs, reduce inappropriate billing, stabilize the ICS provider market, and improve access to community-integrated housing options.

Rationale/Background:

Integrated Community Supports (ICS) is a 245D-licensed waiver service implemented in stages beginning in January 2021 for adults on the Brain Injury (BI) and Community Access for Disability Inclusion (CADI) waivers, and in January 2023 for individuals on the Community Alternative Care (CAC) and Developmental Disabilities (DD) waivers. ICS was introduced as part of Minnesota's Home and Community Based Services (HCBS) Settings Transition Plan, in response to federal Medicaid requirements that people receiving Medicaid home and community-based services have full access to community life and choice.

ICS settings are multi-family housing units (typically apartment buildings of three or more units) where the provider owns, leases, or financially controls the housing units ("provider-controlled settings"). The person receiving ICS lives in their own unit, which includes sleeping, bathing, cooking, and living spaces. While the provider controls or manages the housing, the ICS model is intended to promote community integration, training, and independent living.

All ICS services are provided on an awake, one-to-one basis, and must involve training or support in at least one of four community living categories: community participation; health, safety, and wellness; household management; or adaptive skills. ICS can be authorized for up to 24 hours per day, but there is no minimum hours requirement to live in an ICS setting. The actual support level is tailored to the person's assessed needs and person-centered support plan.

ICS, established in 2021, is a new service and does not replace any former or existing waiver service. ICS cannot be authorized concurrently with any other residential waiver service or with 24-hour emergency assistance, caregiver living expenses, individualized home supports, night supervision, or respite. As of December 2025, there were 260 ICS providers and 487 approved ICS settings, covering 2,850 individual ICS units. Although ICS was created to expand options for individuals with disabilities to live in community-based settings with structured support, DHS monitoring shows that ICS provider growth has outpaced utilization in many metro and non-metro areas, and that provider capacity and setting approval processes are creating implementation challenges.

ICS was designed to fill specific gaps on disability waivers by offering a supportive apartment-based living option for people who need training and assistance but are not best served by congregate or traditional residential care settings. However, community partners and DHS oversight staff have identified several implementation risks and structural challenges:

- The current daily rate methodology does not align with the 15-minute service delivery model, creating mismatches between billing and actual supports.
- Billed units are not always consistent with services actually delivered.
- Service authorizations do not consistently reflect the person's assessed needs and choices.
- Housing is often tied to service providers, limiting informed choice and independence.
- Growth in provider supply has exceeded consumer demand in some areas, raising concerns about system sustainability and quality oversight.

In September 2025, Governor Walz issued Executive Order 25-10 directing DHS to expand fraud prevention and program-integrity safeguards across Medicaid Home and Community-Based Services (HCBS), including a permanent prepayment review process for high-risk waiver services such as ICS. As part of that initiative, DHS instituted a temporary licensing moratorium for new HCBS 245D providers beginning January 1, 2026. This proposal responds directly to the above concerns by building on those actions by realigning the rate methodology, strengthening oversight, clarifying authorization and billing processes, disentangling funding streams for housing and waiver services, and sustainably managing ICS provider growth.

Proposal:

This proposal implements a coordinated set of reforms to strengthen program integrity, align service delivery with federal requirements, and improve long-term sustainability within Integrated Community Supports (ICS). These reforms address rapid growth in ICS licensure and provider-controlled settings, discrepancies between billed and delivered services, and ongoing concerns regarding the entanglement of housing and waiver-funded services.

Alignment of ICS rate methodology with actual service delivery

Effective January 1, 2027, this proposal converts Integrated Community Supports from a daily rate to a 15-minute unit-based payment structure, aligning ICS with Minnesota's other unit-based waiver services and ensuring that rates accurately reflect the level of support delivered.

To support predictable, person-centered service planning and prevent excessive unit inflation, the proposal also establishes the following case-mix-based maximum allowable daily service hours within the rate methodology based on the assessed needs of the person:

Case Mix Classification	Maximum Billable In-Person Hours per Day
A, C, L	2 hours
B, D, F	4 hours
E, G, I, J, K	6 hours
H	8 hours

These limits standardize expectations for typical support needs and prevent over-authorization while preserving flexibility. Individuals with exceptional or complex needs may continue to receive rate-exception approvals above the standard limits. DHS will implement corresponding MMIS/system edits to prevent entry of units above allowable parameters.

Together, these changes promote equity, reduce variation in authorization practices across lead agencies, and improve fiscal integrity by tying payment to actual service provision.

Stable Housing Options through Housing Support
This proposal will support access to Housing Support for eligible individuals residing in ICS and will help ensure funding streams for service provision and housing are distinct and separate. This proposal supports stable housing options for eligible individuals residing in ICS by providing one-time funding to expand or replicate a collaborative model that connects people who are receiving services with Housing Support assistance.

Under this model, individuals receiving ICS who need help paying their housing costs can be referred to a reputable Housing Support provider that operates under the authority of a multi-agency Housing Support agreement. That provider will help people apply and maintain eligibility for Housing Support within their respective human services agency. Once approved, the Housing Support provider will pay rent, utilities, and other allowable expenses on behalf of the individual. The provider will also assist the individual with the annual Housing Support eligibility recertification process.

Because the funding streams for housing and services in this model are separated, an individual could choose to change their ICS provider while still retaining eligibility for Housing Support. This supports state efforts to promote individual choice while strengthening access to community-integrated housing options.

Federal compliance: Prohibition on room and board payments
This proposal codifies federal HCBS requirements by prohibiting the use of Medicaid funds or provider operating margins to pay, subsidize, or offset rent, utilities, or any other room-and-board costs (Minn. Stat. § 256B.4912, subd. 17). This clarifies the boundary between waiver-funded services and housing and strengthens Minnesota's compliance with 42 C.F.R. §§ 441.301 and 441.310.

Strengthened program integrity tools for ICS billing
This proposal codifies the commissioner's ability to require pre-payment review of ICS claims, consistent with Executive Order 25-10. The Office of Inspector General (OIG) will use enhanced methods—including requiring wet signatures and electronic visit verification (EVV), along with utilizing statistically valid sampling—to ensure that billed units reflect actual service delivery.

Electronic Visit Verification
Electronic Visit Verification (EVV) is a federally required system used to verify that certain home and community-based services are delivered as authorized and billed. EVV electronically documents the type of service provided, the date of service, the individual receiving services, the service provider, the location of service delivery, and the time the service begins and ends. Minnesota began implementing EVV in 2022 for the Personal Care Assistance (PCA) program and select waiver services in response to federal requirements intended to strengthen program integrity, ensure accountability, and reduce fraud, waste, and abuse.

This proposal modifies state law to expand EVV requirements to Integrated Community Supports providers effective January 1, 2027. Under this proposal, ICS providers would be required to use an approved EVV system to document service delivery in accordance with state and federal requirements. Requiring EVV for ICS would align this service with other home and community-based services that already utilize EVV, promoting consistency, transparency, and accurate billing across programs.

Improved authorization accuracy and person-centered oversight
Under this proposal, Integrated Community Supports (ICS) service authorizations will be aligned with a unit-based authorization framework that reflects the scope, intensity, and duration of services to be delivered. The Department of Human Services (DHS) will implement additional prior-authorization review checkpoints for higher-cost service packages to ensure that authorized service levels are consistent with assessed need and program expectations. Lead agencies will be required to document that ICS authorizations are based on current assessments, individual goals and preferences, and established case-mix parameters. Many of these requirements are already in place through existing assessment, care planning, and authorization processes; this proposal

clarifies expectations, strengthens oversight for higher-cost services, and promotes consistent authorization practices statewide while reducing the risk of over-authorization.

Separate moratoria on ICS service licenses and ICS settings
To better manage system growth and improve alignment with federal requirements, the proposal establishes two distinct permanent moratoria:

- **ICS service license moratorium (Minn. Stat. § 245A.03):** The commissioner may not issue a new 245D license authorizing ICS or approve an amendment adding ICS unless an exception is granted. Exceptions require compliance with federal HCBS requirements, the room-and-board prohibition, and documentation standards under chapter 245D. This moratorium applies specifically to service licensure.

- **ICS provider-controlled setting approval moratorium (Minn. Stat. § 256B.492):** Because ICS settings are HCBS settings rather than licensed facilities, a separate moratorium regulates the creation or expansion of ICS provider-controlled settings. Exceptions require federal HCBS compliance, independent lease requirements, documentation under § 245D.12, and a determination that the approval is necessary to prevent displacement or meet regional capacity needs.

Together, these moratoria give DHS the tools to manage system growth responsibly while protecting housing rights and preserving service quality.

Summary of Proposal
This package of reforms strengthens the ICS delivery system by aligning rates with actual service delivery, safeguarding housing rights, ensuring billing accuracy, promoting person-centered authorization practices, and responsibly managing provider growth. The proposal enhances program integrity, supports community integration, and protects both individuals and the long-term viability of ICS services in Minnesota.

Fiscal Impact
Dollars in Thousands

Below is the fiscal impact of this proposal by component:

Proposal Component	FY26	FY27	FY28	FY29
ICS 15 min Framework	0	(1,264)	(13,410)	(17,739)
ICS EVV Component	0	(66)	(652)	(860)
Housing Support	0	3,717	13,508	15,209
Total	**0**	**2,387**	**(554)**	**(3,390)**

Below is the detailed fiscal tracking for this proposal:

Net Impact by Fund (dollars in thousands)			FY 26	FY 27	FY 26-27	FY 28	FY 29	FY 28-29
General Fund			0	2,387	2,387	(554)	(3,390)	(3,944)
HCAF								
Federal TANF								
Other Fund								
Total All Funds			0	2,387	2,387	(554)	(3,390)	(3,944)
Fund	**BACT#**	**Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**

GF	33	MA FFS	0	(1,377)	(1,377)	(13,527)	(17,856)	(31,383)
GF	33	MA FFS - EVV Improper Payments	0	(66)	(66)	(652)	(860)	(1,512)
GF	11	MnCHOICES Systems	0	13	13	0	0	0
GF	14	ICS Rate Exceptions Admin (0,.75,1,1)	0	147	147	172	172	344
GF	REV1	Admin FFP @ 32%	0	(47)	(47)	(55)	(55)	(110)
GF	25	Housing Support Program Impacts	0	2,467	2,467	13,508	15,209	28,717
GF	56	HHSSA Provider Grant: July 1, 2026	0	1,250	1,250	0	0	0
Fund	**BACT#**	**FTEs Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	14	ADSA FTE (0,.75,1,1)	0	0.75		1.00	1.00	

Impact on Children and Families

This proposal indirectly supports children and families by ensuring waiver funds are used appropriately, reducing fraud/waste, and promoting housing stability for people with disabilities.

Equity and Inclusion:

Stronger oversight promotes fair and sustainable distribution of waiver resources, benefitting all communities. Risks include potential provider contraction. DHS will monitor for disproportionate impacts on marginalized populations and address them through stakeholder engagement and housing reinvestments.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:

Counties will have expanded responsibility to ensure service authorizations align with person-centered needs and to support individuals in transitioning to independent housing arrangements.

IT Costs

This proposal has IT costs of $50,000 for MnChoices changes to the ICS rate framework.

Category	***FY 2026***	***FY 2027***	***FY 2028***	***FY 2029***
Payroll				
Professional/Technical Contracts	0	13	0	0
Infrastructure				
Hardware				
Software				
Training				
Enterprise Services				

Category	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*
Staff costs (MNIT or agency)	0		0	0
Total	**0**	**13**	**0**	**0**
MNIT FTEs				
Agency FTEs				

Results:
The ICS Oversight Package aims to ensure service authorizations and billing align with actual service delivery, promote housing stability, and strengthen fiscal integrity. Success will be measured by reductions in billing discrepancies, improved person-centered authorizations, and sustained provider participation.

Quantitative Performance Measures

Measure	Type	Source	Baseline	Target
% of ICS daily rate agreements converted to 15-minute units	Quantity	MMIS claims data	0% (2025)	100% by FY28
% of service agreements audited with billing discrepancies	Quality	OIG audits	Baseline to be established FY25	25% reduction within 2 years
% increase in accepted referrals under centralized Housing Support model	Result	Agency reporting	To be determined	Increase accepted referrals by at least 25% in FY28 and maintain a minimum 25% growth rate in FY29
Number of ICS providers operating above approved capacity	Quantity	MMIS provider data	Baseline to be established	Reduced to 0% within 2 years

Qualitative Measures

- Stakeholder feedback from counties, providers, and people receiving services.
- Case examples of increased independence and informed choice in housing.

Evidence
Draws from DHS fiscal monitoring and oversight experience; no formal evaluation yet, but oversight practices align with Medicaid program integrity standards.

Department of Human Services
FY 2026-27 Biennial Budget Change Item

Change Item Title: Housing Stabilization Services Termination and Redesign (HS-54)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	**0**	**0**	**0**	**0**

Request:

The Governor recommends updating statute to align with the termination of the Housing Stabilization Services program and directing the Department of Human Services to develop recommendations to redesign a new housing services benefit with robust program integrity and service quality requirements by September 15, 2027.

Rationale/Background:

Housing Stabilization Services (HSS) was a Medical Assistance benefit and 1915(i) Home and Community-Based Service that helped seniors and people with disabilities, including mental illness and substance use disorder, find and maintain housing. On August 1, 2025, the Department of Human Services, under the guidance of its Office of Inspector General, sent a letter to the Centers for Medicare and Medicaid requesting authorization to terminate the program. The program ended October 31, 2025.

According to preliminary data from the 2025 Point-in-Time Count, nearly 8,400 people experienced homelessness on a single night in Minnesota. Redesigning a new program with robust program integrity and service quality requirements is needed to address a critical gap in housing services that help prevent homelessness and enhance the health of people experiencing housing instability.

Proposal:

This proposal updates state statute to align with the termination of the state's Housing Stabilization Services program.

This proposal also directs the Department of Human Services to work with community partners, counties, Tribes, and the legislature to develop recommendations by September 15, 2027, for a redesigned program that supports access to housing services, with foundational program integrity controls. The redesign project also requires establishing a housing services benefit specifically for and responsive to the unique needs, sovereignty, and federal recognition of Minnesota Tribal Governments and Urban Indian Organizations.

Fiscal Impact

This proposal is budget neutral.

Dollars in Thousands

Net Impact by Fund	FY 25	FY 26	FY 27	FY 25-27	FY 28	FY 29	FY 28-29
General Fund							

Other Fund 1									
Other Fund 2									
		Total All Funds							
Fund	**BACT**	**Description**	**FY 25**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
Requested FTEs									
Fund	**BACT**	**Description**	**FY 25**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**

Impact on Children and Families:

According to the 2023 Minnesota Homeless Study, children and youth (age 24 and younger) account for 4 out of every 10 people experiencing homelessness, and people in families (with children under 18) account for nearly half (47%) of people experiencing homelessness. The impacts of homelessness and housing instability on young people are well documented, including brain development, behavior, relationships, and employability.

Needs and ability to serve children and families experiencing homelessness or housing instability will be considered as part of conversations with community partners, counties, Tribes, and the legislature to redesign and relaunch a housing services benefit.

Equity and Inclusion:

American Indian, Black, and Latino Minnesotans are overrepresented in the population experiencing homelessness. Data from the Point-in-Time Count and American Community Survey show that American Indians are 31 times more likely to experience homelessness than white Minnesotans; Black Minnesotans are 11 times more likely, and Latino Minnesotans are 8 times more likely.

Addressing Minnesota's racial disparities in homelessness will be a key part of conversations to redesign and relaunch a housing services benefit.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

The 2025 legislature directed the Department of Human Services to submit a state plan amendment to the Centers for Medicare and Medicaid Services (CMS) to establish a Tribal encounter rate connected to Housing Stabilization Services. With the termination of Housing Stabilization Services, this is no longer possible, and a new alternative must be established.

This proposal includes a dedicated approach to establishing a Tribal housing benefit. The Department of Human Services will continue to engage Tribal Nations through formal government-to-government consultation and work in tandem with Tribal programs, Urban Indian organizations, and community to co-create a housing services

benefit specifically for and responsive to the unique needs, sovereignty, and federal recognition of Minnesota Tribal governments and Urban Indian organizations.

Impacts to Counties:
The Department of Human Services will work with counties and other community partners to develop recommendations to redesign a program with robust program integrity and service quality requirements.

IT Costs
There are no IT costs in this proposal.

Results:
The development of recommendations for a new housing benefit will include recommendations for how program outcomes will be measured.

Statutory Change(s):
- Minn. Stat. § 245C.03, subd. 6
- Minn. Stat. § 245C.04, subd. 6
- Minn. Stat. § 245C.10, subd. 6
- Minn. Stat. § 256B.04, subd. 21
- Minn. Stat. § 256B.051
- Minn. Stat. § 256B.0658
- Minn. Stat. § 256L.03, subd. 1
- Laws 2025, first special session, chapter 3, article 18, section 3

Department of Human Services
FY 2026-27 Biennial Budget Change Item

Change Item Title: Uniform Service Standards (USS) Implementation (IG-52)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund		262	200	200
Expenditures				
Revenues				
Other Funds		1,299	691	367
Expenditures	0			
Revenues	0			
Net Fiscal Impact = (Expenditures – Revenues)	0	1,561	891	567
FTEs	**0**	**10.5**	**14**	**14**

Request:
The Governor recommends fully implementing the Mental Health Uniform Service Standards (USS), which transitions certifications to licenses for outpatient and rehabilitative mental health.

This proposal requires additional funding in FY27 and FY28, which is offset partially with the introduction of a one-time application fee and the license renewal and offsite satellite provider fees. In FY29, the renewal and satellite fees for the new USS licensed services will offset the cost of the FTEs and software licenses within this request.

Rationale/Background:
Uniform Service Standards (USS) is a multiyear effort to increase program integrity, reduce barriers to care, and ensure equitable access to mental health services. In previous legislative sessions DHS was instructed to develop licensing standards for four mental health services that are currently certification programs. Those services are Children's Therapeutic Services and Supports (CTSS), Adult Rehabilitative Mental Health Services (ARMHS), Crisis Response Services and Certified Community Behavioral Health Clinics (CCBHC) services. The licenses will be placed into the licensing hub system. Licensing these programs will provide enhanced and necessary oversight.

Proposal:
This is the continuation of a multi-year project to license CTSS, ARMHS, Crisis Response Services, and CCBHC, which are currently certified by DHS. In the 2023 legislature appropriated initial funds to implement licensing standards for these services. This proposal puts licensing standards in state statute, clarifies fees related to licensing, and appropriates the remaining implementation funding needed to implement.

This proposal includes 14 FTEs needed to fully implement the USS licensing transformation. The costs are approximately $1,561,000 in FY27, with license renewal and satellite provider fees reducing costs in FY28 and in FY29.

The licensing hub also requires the purchase of an additional 79 Salesforce licenses. Each licensor and department staff member who uses the system to edit, process or document an item in the licensing process requires a license. There is also a need for 35 service cloud voice licenses. These cloud voice licenses are required for staff that take phone calls and must log those calls to create an action or workflow item in the licensing hub system.

In addition to FTEs and software licenses, this request includes policy language which set the requirements in statute to effectuate the transition from certification to license. Based on the progress of earlier phases of USS, codification of the licensing structure is essential to starting IT work. The licensing hub will be capable of issuing

licenses starting on July 1, 2027. The department will make the application available for the first USS licensed program by April 2, 2027. The department will then license the programs on a rolling basis – approximately once every three months.

Fiscal Impact:

The 2023 legislative session appropriation provided enough funds for approximately half of the contingent of FTEs needed to fully implement USS. The FTEs are largely centered on licensors plus additional intake, support, and legal positions. Licensor caseload is 50 providers to one licensor. The proposal will implement new NetStudy 2.0 background studies for these providers, which will require background studies staff to perform. The request also requires licensed software in the form of Salesforce and cloud voice licenses at $1,860.50 for 79 licenses and $590 for 35 licenses. The license costs totaling of $147,000 in Salesforce licenses and $21,000 in cloud voice licenses.

Dollars in Thousands

Net Impact by Fund			**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
General Fund			-	262	262	200	200	400
State Government Special Revenue Fund			-	1,299	1,299	691	367	1,058
Total All Funds			-	1,561	1,561	891	567	1,458
Fund	**BACT**	**Description**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
SGSR	18	OIG FTEs (0,14, 14, 14)	-	2,013	2,013	2,352	2,352	4,704
GF	11	Background studies NETStudy 2.0	-	62	62	25	25	50
GF	11	Adobe Experience Manager (AEM)	-	26	26	5	5	10
GF	11	MNIT NS2 changes and maintenance	-	6	6	2	2	4
SGSR	REV2	Provider Application Fee (one-time fee)	-	(714)	(714)	(502)	-	(502)
SGSR	REV2	Provider Renewal Fee (annual)	-	-	-	(1,020)	(1,773)	(2,793)
SGSR	REV2	Satellite Fee Revenue	-	-	-	(139)	(212)	(351)
GF	11	Salesforce licenses	-	147	147	147	147	294
GF	11	Cloud voice licenses	-	21	21	21	21	42
Requested FTEs								
Fund	**BACT**	**Description**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	18	OIG FTEs	0	10.5	14	14	14	14

Impact on Children and Families:

Currently, outpatient mental health services do not have standard use of NetStudy 2.0 or have maltreatment investigation authority for children. Implementing uniform standards helps ensure a safe and healthy environment for all children. Providers of mental health services also indicate that overly complex regulation

hampers their ability to reach as many children as possible, which is critical during a time of provider shortages and waitlists.

This proposal builds on and implements work that DHS has done already to streamline requirements and processes for providers. Based on the work done in 2021 and 2023, providers have more flexibility on revising treatment plans, the ability to engage children in services while developing rapport and trust necessary for a comprehensive assessment of their trauma history, and overall streamlined requirements when serving children and families. Minnesota children and families benefit when the state breaks down siloes and idiosyncratic processes.

Equity and Inclusion:

We anticipate that this proposal will increase equity in Minnesota's delivery of mental health services by clarifying for people the requirements for providing a specific service. OIG Licensing has clear processes for issuing licenses, monitoring compliance with requirements, informing providers of noncompliance, and allowing providers reconsideration and appeal rights. Simplifying and clarifying the service evaluation process will allow providers to meet requirements while reducing their administrative burden. DHS also plans significant communication and using a period of focus on technical assistance during the transition.

Nationally, seclusion and restraint have been found to be used with children of color more than white children. In available research, the incidence rate was highest with Black children. This proposal would provide a recognized avenue for children or parents to raise the concern with DHS about seclusion/restraint in CTSS day treatment programs and have the state investigate.

Some providers may close due to the implementation of a new licensing fee for their provider type. The providers most impacted will be smaller providers with lower revenues. There is a higher number of culturally specific providers among smaller providers, and thus they would be disproportionately impacted.

Tribal Consultation:

☒Yes
☐No

Currently, seven programs operated by Tribal Nations would be included in this proposal. DHS has presented information on the broader USS project several times at the American Indian Mental Health Advisory Council. As with other providers, Tribes will benefit from clear and streamlined requirements for services. While there is some work necessary to come into compliance with any changed standards, the overall impact is expected to be a net reduction in the time and resources needed.

Tribal providers gave significant input for Phase One of this project, especially around barriers to accessing care that existed in the requirements for diagnostic assessments.

Impacts to Counties:

Counties are not anticipated to be impacted.

IT Costs:

Category	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*	*FY 2030*	*FY 2031*
Payroll						

Category	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*	*FY 2030*	*FY 2031*
Professional/Technical Contracts						
Infrastructure		94	32	32	7	7
Hardware						
Software		168	168	168	168	168
Training						
Enterprise Services						
Staff costs (MNIT or agency)						
Total						
MNIT FTEs						
Agency FTEs						

Results:

Part A: Performance Measures

5. The goal of this change item is to complete the transition of Children's Therapeutic Services and Supports (CTSS), Adult Rehabilitative Mental Health Services (ARMHS), Crisis Response Services, and Certified Community Behavioral Health Clinics (CCBHC) into DHS's licensing framework, aligning them with other comparable behavioral health services. The expected outcomes are greater program integrity, standardized oversight, equitable access to services, and enforceable protections against fraud, waste, and abuse.
6. Stakeholder input from organizations such as MHLN, MACMHP, and ASPIRE indicates support for licensing as a tool to reduce barriers to care and improve service quality, despite concerns about fee structures. Additionally, services with higher risks of fraud, waste, and abuse (such as CTSS and ARMHS) benefit from more structured licensing oversight.
7. The successful implementation of USS will be when the statutory language is supported by an adequate licensing hub tool and application and licensing fee structure that can support a large portion of the costs of administering the program.

Measure	**Measure type**	**Measure data source**	**Most recent data**	**Projected change**
Briefly write what is being measured.	*Select quantity, quality, or result. Please try to include 1 of each.*	*Describe how the data for this measure will be collected.*	*If currently collected, provide most recent data for this measure. If not currently collected, please write N/A.*	*If successful, describe the change expected on this measure and to what extent.*
Implementation of four different certifications as licenses in law and licensing hub.	The statutory and license hub framework	The statutory changes in Minnesota statutes and a fully functional licensing system through the Provider Hub.	N/A	On the expected date 4/2/2027 the application for licensure begins operating.

Measure	Measure type	Measure data source	Most recent data	Projected change
	to make this transition.			
Collection of application and licensing fees.	Applications and licenses for providers.	Every provider will need to pay for an application fee or license renewal fee.	N/A	There should be new revenue from a fee structure.

Part B: Use of Evidence

5. Have you previously conducted a formal quantitative or qualitative program evaluation that informed the contents of this proposal? If so, please briefly describe the evaluation. No.
6. Are you planning to conduct a formal qualitative or quantitative program evaluation related to this proposal? Indicate what kind(s) of evaluation you will be conducting. Select all that apply.

   X No formal evaluation planned at this time
   __ Not yet determined
   __ Needs Assessment
   __ Process or Implementation Evaluation
   __ Summative Impact Evaluation (Randomized Control Trial (RCT) or Quasi-Experimental Design)
   __ Summative Evaluation other than an Impact Evaluation
   __ Other (please describe or link):

Statutory Change(s):

245A.03; 245A.10; Section is added, provisionally coded 245A.044; 245I.011; 245I.02; 245I.03; 245I.04; 245I.06; 245I.07; 245I.10; Section is added, provisionally coded 245I.22; Section is added, provisionally coded 245I.24; Section is added, provisionally coded 245I.30; A section is added, provisionally coded 245I.31; Section is added, provisionally coded 245I.17; 256B.0624, 256B.0943; 256B.0623; 245.735; 260E.14; 626.5772; 245A.65; 245C.03. Repeal: 245I.20, subd 9; 245I.23 subd 23; 256B.0623: subd 2, 4, 5, 6, 9; 256B.0624: subd 2, 3, 4a, 5, 6, 6a, 6b, 7, 8, 9, 11; 256B.0943, subd 1, 4, 5, 5a, 6, 7, 9, 11; 245.735 subd 3f, 4a, 4b, 4c, 4d, 4e, 7, 8; 245C.03 subd 7.

Department of Human Services

FY 2026-27 Biennial Budget Change Item

Change Item Title: Earlier Effective Date for Improving Supportive Housing Options (BH-53)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	(9,163)	(1,784)	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	(9,163)	(1,784)	0
FTEs	**0**	**0**	**0**	**0**

Request:

The Governor recommends amending the Recovery Residence Certification initiative enacted during the 2025 legislative session to accelerate the implementation timeline. This proposal advances the certification requirement for recovery residences and the phase-out of Free-Standing Room and Board (FSRB) programs.

The fiscal impact of this change includes accelerated savings, with FSRB phase-out savings beginning in FY 2027 (one year earlier than originally proposed) and continuing through subsequent biennia. The certification body funding structure remains unchanged.

Rationale/Background:

The original Recovery Residence Certification proposal established July 1, 2027, as the initial certification date for sober homes wishing to achieve certification as recovery residences. That timeline was designed to provide adequate time f to develop a certification process and transition of existing facilities to meet nationally recognized Recovery Residence Best Practices standards.

However, recent analysis and stakeholder feedback have indicated that the certification infrastructure can be established more rapidly than initially anticipated. Additionally, the continued rapid expansion of FSRB providers—with 13 new locations approved in 2024 compared to only 4 in 2020—demonstrates an urgent need to accelerate the transition timeline to control costs and ensure appropriate care standards.

By moving the certification date to July 1, 2026, the State will:

- Realize cost savings one year earlier, as the FSRB phase-out will begin in FY 2026 rather than FY 2027, providing additional resources to support the housing alternatives being developed through the workgroup process.
- Ensure that individuals currently in FSRB settings transition more quickly to either licensed residential treatment facilities (for those requiring that level of care) or appropriate recovery housing with supportive services (for those requiring a lower level of care).
- Provide stronger consumer protections for residents in certified recovery residences.

The original proposal noted that "individuals currently in FSRBs may not require a full residential level of care but still need supportive housing in a recovery-oriented environment." The accelerated timeline ensures that these individuals can access appropriate, certified housing options more quickly, while those who do require residential treatment are directed to licensed facilities with proper oversight and protections.

Proposal:
This proposal maintains all elements of the original Recovery Residence Certification proposal with the following key modifications to implementation dates:

- Certification Requirement Date: Recovery residences can now be certified beginning in July 1, 2026 (amended from July 1, 2027), in accordance with Minnesota Statutes 254B.181 and Recovery Residence Best Practice standards.
- FSRB Phase-Out Timeline: The phase-out of Free-Standing Room and Board has already begun, with FSRB provider enrollment ending in June 2025. The program will now completely cease on December 31, 2026.
- Starting July 1, 2026, DHS will have the authority to enter into Housing Support agreements directly with eligible certified recovery residences. Recovery residences will still need to meet all the criteria for Housing Support under 256I.04.
- Workgroup Deliverables: The workgroup studying alternative housing models and payment structures will be required to deliver its implementable plan by January 1, 2027 (six months earlier than the original timeline) to ensure housing alternatives are available before the accelerated transition date.

All other elements of the original proposal remain unchanged, including:

- Establishing certain standards for all recovery residences
- Creating an optional certification process for recovery residences that wish to become certified, in order to be included on the public database of certified recovery residences or receive Housing Support payments
- Funding of $150,000 over two years for the workgroup studying payment models and housing alternatives
- Change in terminology from "sober homes" to "recovery residences"

Impact on Children and Families:
The impacts on children and families remain consistent with the original legislative intent. Accelerating the timeline means families will benefit sooner from the enhanced protections and standards that certified recovery residences provide. Earlier access to appropriate, certified recovery housing may reduce family stress and improve outcomes for individuals in recovery, thereby benefiting entire family systems more quickly.

Equity and Inclusion:
The equity and inclusion considerations remain consistent with the original legislative intent. The accelerated timeline makes it even more critical to ensure that the workgroup and certification body prioritize culturally specific recovery housing needs and provide adequate support for smaller facilities serving marginalized communities. The compressed timeline necessitates proactive outreach and technical assistance to ensure that providers serving African American, American Indian, and other diverse populations can successfully achieve certification by July 1, 2026.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Consistent with the original proposal, while this proposal does not have a direct effect on Tribal governments, the workgroup will include a representative from the Tribal Nations and will ensure Tribal perspectives inform the development of housing alternatives.

Impacts to Counties:

Counties will benefit from the accelerated timeline through earlier realization of reduced hospitalizations, detox admissions, local correctional involvement, and emergency shelter uses. The workgroup will continue to include county representatives to ensure local perspectives inform implementation.

IT Costs

No IT changes are necessary for this proposal.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 26	FY 27	FY 26-27	FY 28	FY 29	FY 28-29
General Fund				(9,163)	(9,136)	(1,784)	0	(1,784)
HCAF								
Federal TANF								
Other Fund								
Total All Funds								
Fund	**BACT#**	**Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	35	BHF FSRB		(19,220)	(19,220)	(1,784)	0	(1,784)
GF	25	Housing Supports (6 Month Phase-In)		10,057	10,057		0	0
		Requested FTEs						
Fund	**BACT#**	**Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**

Statutory Change(s):

256I.04, subd. 2a

Department of Human Services

FY 2026-27 Biennial Budget Change Item

Change Item Title: Market and Receipt-Based Rate Reform for Disability and Older Adult Services (AD-64)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	(504)	(2,167)	(2,369)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	(504)	(2,167)	(2,369)
FTEs	**0**	**0**	**0**	**0**

Request:

The Governor proposes capping administrative fees for certain services within the disability waivers and programs serving older adults, including Alternative Care, Essential Community Supports, and Elderly Waiver, at 6%. The governor also proposes one-time funding to study and recommend rate methods for market-based services to ensure appropriate payment rates.

Rationale/Background:

Currently, there is no explicit limit on the administrative fees an enrolled provider or lead-agency approved vendor may charge for arranging or delivering a market-rate or receipt-based service. In practice, this has led to situations where some providers—such as those offering Chore Services—require service agreements to authorize the maximum allowable rate, regardless of the actual cost of the specific task or service provided. This practice can inflate authorized costs and create inequities in the use of waiver funding.

This issue was identified as part of DHS's ongoing monitoring of waiver service agreements. This proposal is data-driven, drawing from service agreements that currently authorize the full allowable rate rather than reflecting the actual cost of the item or service provided. This disconnect highlights the need for statutory clarification to ensure accuracy, prevent misuse of waiver funds, and promote equitable allocation of resources.

Although there is no clear evidence of similar reforms in other states or a broader national conversation on this specific issue, the intended result is to improve integrity in the Disability Waiver Rate System and Aging programs. By clarifying limits on allowable expenses, DHS can safeguard waiver funds and promote more sustainable and equitable use of resources.

In addition to requiring limits to administrative fees on market rate and receipt-based services, this proposal also seeks to improve rate methodologies. Currently, services with rates determined through market-rates have rates that are negotiated between lead agencies and providers. This results in a large variability in rates across the state and a lack of a standardized approach for service payments.

Proposal:

This proposal adds a statutory clarification regarding allowable expenses for market-rate or receipt-based services available under the disability waivers and aging programs (EW/AC/ECS), limiting administrative fees to a

maximum of 6%. This is needed to address concerns raised by lead agencies, to ensure consistent, fair application of waiver funding, and to ensure that services paid reflect actual costs.

This proposal also provides one-time funding for an independent contractor to study rate setting methodologies for services currently offered under market rate methodologies and homemaking services. The study will provide a recommendation for appropriate rate methodology in Minnesota that accommodates current market and cost trends.

Services in scope for the study include:

- Market Rate Services: 24-hour emergency assistance, Assistive technology, Caregiver living expenses, Chore services, Crisis respite, Environmental accessibility adaptations, Family training and counseling, Respite, Specialist services, Specialized equipment and supplies, Transitional services (BI, CAC, CADI, DD), and Transportation (waiver transportation)
- Homemaking Services provided under the disability and older adults programs

This study will ensure that rate methodologies appropriately reflect the costs of providing services. The study will provide recommendations and a report to the legislature by February 15, 2027.

Fiscal Impact

Dollars in Thousands

Net Impact by Fund (dollars in thousands)			FY 26	FY 27	FY 26-27	FY 28	FY 29	FY 28-29
General Fund			0	(504)	(504)	(2,167)	(2,369)	(4,536)
HCAF								
Federal TANF								
Other Fund								
Total All Funds			0	(504)	(504)	(2,167)	(2,369)	(4,536)
Fund	**BACT#**	**Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	33	MA LW FFS	0	(630)	(630)	(1,611)	(1,765)	(3,376)
GF	34	AC- Limit Fees	0	(4)	(4)	(11)	(12)	(23)
GF	33	MA Elderly Waiver FFS (10%)	0	(21)	(21)	(55)	(59)	(114)
GF	33	MA Elderly Waiver MC (90%)	0	(189)	(189)	(490)	(533)	(1,023)
GF	14	Vendor Contract	0	500	500	0	0	0
GF	REV1	Admin/Contract FFP @ 32%	0	(160)	(160)	0	0	0

Impact on Children and Families

This Governor's proposal is not directly tied to innovations in children's services, but several lead agencies raised concerns that prompted the need for statutory clarification. The issue centers on allowable expenses for market-rate and receipt-based services under the disability waivers and Aging programs, which, if left unaddressed, could create inequities in access to services.

Equity and Inclusion:

This proposal has potential implications for equity. Clarifying allowable expenses may result in fewer providers enrolling to deliver certain market-rate or receipt-based services, which could affect availability and access for

Minnesotans who rely on them. Any reduction in provider participation would have disproportionate impacts on people with disabilities and older adults, including those from Native, Black, Latine/Latinx, Asian American, LGBTQ+, rural, and veteran communities.

While the proposal is not explicitly designed to reduce inequities, its purpose is to promote fair and consistent use of waiver and aging program funds, which indirectly supports equity by ensuring that resources are used as intended and distributed more fairly across communities. The risk of reduced access will need to be monitored closely to ensure equitable outcomes.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
This proposal is not expected to impact counties, but it does meet a need they have raised to DHS.

IT Costs
There are no IT costs in this proposal.

Results:
This proposal will result in reduced state expenditures and service rates that more closely reflect costs.

The report in this proposal will provide independent evaluation for future rate reform to ensure that market rate services and homemaker services are paid at appropriate rates.

Part B: Use of Evidence

7. Have you previously conducted a formal quantitative or qualitative program evaluation that informed the contents of this proposal? If so, please briefly describe the evaluation. No
8. Are you planning to conduct a formal qualitative or quantitative program evaluation related to this proposal? Indicate what kind(s) of evaluation you will be conducting. Select all that apply.

   X No formal evaluation planned at this time
   __ Not yet determined
   __ Needs Assessment
   __ Process or Implementation Evaluation
   __ Summative Impact Evaluation (Randomized Control Trial (RCT) or Quasi-Experimental Design)
   __ Summative Evaluation other than an Impact Evaluation
   __ Other (please describe or link):

Department of Human Services
FY 2026-27 Biennial Budget Change Item

Change Item Title: Enhancing Program Integrity and Quality in Nursing Home Rates (AD-46)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	(14,937)	(27,146)	(29,654)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	(14,937)	(27,146)	(29,654)
FTEs	**0**	**0**	**0**	**0**

Request:

The Governor recommends making changes to nursing facility payments to enhance program integrity in rates paid to nursing facilities and to enhance quality of care provided to Minnesotans. This proposal includes the following changes: end the Planned Closure Rate Adjustment (PCRA) program; place maximum limits to reimbursement for employee health insurance costs; end the Performance-based Incentive Program (PIPP); and modify the formula used to establish the quality-based care related operating limits to align reimbursement of care-related costs with individual nursing facilities quality performance.

This proposal is estimated to save $14.94 million in the FY26-27 biennium and $56.80 million in the FY 28-29 biennium (general fund dollars) which represents about 3.83% of total annual Medicaid spending on nursing facilities.

Rationale/Background:

Planned Closure Rate Adjustment

The Planned Closure Rate Adjustment program (PCRA) has operated almost continuously since 2001. Under this program, the state has allowed rate adjustments related to partial or complete nursing facility closures. These rate add-ons were intended to incentivize the permanent closure of nursing facilities beds and compensate the nursing facility for the bed closures. This program was suspended temporarily in 2011. More than 3,500 nursing home beds have been closed under the PCRA program since 2009.

The PCRA program was implemented at a time when reimbursement rates were not cost-based and the state had a surplus of nursing facility beds. However, circumstances in Minnesota changed years ago. The rates paid to nursing homes are now set based on the Value-Based Reimbursement (VBR) system, which reimburses providers based on their actual costs. Under VBR, payment rates are adjusted to reflect increases in fixed costs per day due to decreases in occupancy. PCRA rate add-ons also pay facilities for reduced capacity as they are added to a nursing facility's rate in addition to VBR. Under current law, these PCRA add-ons are paid in perpetuity until the nursing facility ceases operation, resulting in paying for reduced bed capacity in both the VBR rate methodology and the PCRA rate add-on. Given that payment rates for nursing facilities are cost-based under VBR and reflect changes in costs due to bed reductions, it is not prudent to continue to pay previously issued bed reduction incentives into perpetuity nor to provide new bed closure payments.

Performance-Based Incentive Payment Program (PIPP)
In 2006, the Minnesota Department of Human Services (DHS) launched the Performance-Based Incentive Payment Program (PIPP). PIPP is a competitive program that selects and funds provider-initiated projects aimed at improving the quality and efficiency of nursing home care. Similar to PCRA, the PIPP program was implemented at a time when reimbursement rates were not cost-based. The program allowed for nursing facilities to pay for additional costs related to these projects. However, under VBR, rates are already adjusted to reflect these costs. It is not prudent to continue to provide a PIPP rate add-on in addition to the VBR cost-based rates, resulting in reimbursement for the same costs twice.

Health Insurance Costs
Prior to cost-based payment rates established under the VBR system, payments to nursing facilities for employee health insurance were included in the operating rates and thus subject to limits. Since VBR removed this reimbursement limit nine years ago, health insurance costs have increased by 69 percent. Some facilities with self-funded health insurance plans were reimbursed more than $30,000 per enrollee per year in the 2024 calendar year, more than triple the state contribution in the current plan year for state employees. The problem this proposal addresses is this current lack of cost containment to control the state's liability for health insurance costs.

Health insurance cost reimbursement is unlimited in the current reimbursement formula whether a provider purchases health insurance through a third-party insurer or self-insures. Given the lack of formula limitations on health insurance, cost containment reliance is upon providers acting as a prudent buyer in obtaining health insurance at the market rate. Unlike third party health insurance, when a nursing home provider chooses to self-insure, the provider is accepting the future liability of any health insurance claims themselves, so the final cost of self-insurance is unknown when contracted. The amount of liability can be limited through the purchase of third-party insurance to provide stop loss coverage. In making the decision to purchase reasonable stop-loss coverage to limit potential cost in the long run, the normal risk consideration is not present because the self-insured costs will be reimbursed 100% through the rates. Consequently, self-insurance costs can often be significantly more than what the expenses would have been under third-party coverage. Some providers are opting for very little stop loss coverage which results in large avoidable losses to the state budget.

Increasing Quality in Nursing Facility Care
The Value-Based Reimbursement (VBR) payment system was implemented on January 1, 2016. VBR calculates daily payment rates based on costs reported by facilities and uses a quality score to set care-related spending limits. As the name suggests, the goal of "Value Based Reimbursement" was to increase the value of nursing home care through increased Medicaid reimbursement targeted to direct care and care-related services and through incentivizing better quality of care via the Medicaid rate setting process. As such, the VBR methodology reimburses based on a provider's costs, but ties payment limits to a nursing home's quality scores.

An independent evaluation of VBR by a team from Purdue University and the University of Minnesota in 2021 found no evidence that VBR's quality incentives led to higher facility quality. Their report noted that as this limit is currently designed, the impact has been minimal on most facilities because the quality limit is structured at a threshold that most nursing homes easily meet. They concluded that a revised threshold formula is needed for the VBR reimbursement system to meet the intended goals of increasing quality for Minnesotans accessing nursing home care.

Proposal:

Planned Closure Rate Adjustment

This proposal ends the Planned Closure Rate Adjustment (PCRA) program effective July 1, 2026. The termination of the PCRA program will cause a decrease to the external-fixed rate for facilities who have received or possibly would have received PCRA adjustments. The decrease to external-fixed rate will vary by facility but will be an average decrease per resident day of $1.20 for CY 2026, $2.42 for CY 2027, $2.47 for CY 2028, and $2.53 for CY 2029. The decreased rates will impact the Medicaid and private pay nursing facility rates effective July 1,2026. This will be implemented by no longer accepting, beginning, or approving applications received prior to the day after following enactment, and by removing the current PCRA.

This proposal ensures that payments to nursing facilities reflect the changes in operating costs due to bed reductions through one mechanism only.

Performance-Based Incentive Payment Program (PIPP)

This proposal ends the Performance-Based Incentive Payment Program (PIPP) effective January 1, 2027. The termination of the PIPP program will cause a decrease to external-fixed rate for facilities that would have received PIPP adjustments. The decrease to external-fixed rate will be different per facility but will be an average decrease per resident day of $2.09 for CY 2027, $3.12 for CY 2028, and $3.88 for CY 2029. The decreased rates will impact the Medicaid and private pay nursing facility rates effective January 01, 2027. This will be implemented by not issuing any new PIPP rate add-ons. Current contracts to pay PIPP rate add-ons all expire on or before December 31, 2026. This proposal does not take away any PIPP rate add-ons that the Department of Human Services has already committed to pay out.

This proposal seeks to make payments to nursing facilities more salient since rates are cost based under VBR and reflect the changes in costs per day. This proposal ensures that costs are only paid for once.

Health Insurance Costs

This proposal caps the amount of allowable health insurance at $15,000 per enrollee. The cap will be inflated annually by the CPI-U as costs for health insurance will likely also inflate annually. The cap to health insurance will cause a decrease to the external-fixed rate for facilities whose health insurance costs are over this cap. The rate decrease will be specific to facilities who are impacted by this cap but will be an average decrease per resident day of $1.26 for CY 2027, $1.29 for CY 2028, and $1.33 for CY 2029. These decreases will impact the Medicaid and private pay nursing facility rates effective on January 01, 2027, reimbursing affected providers the lower of actual or the capped health insurance costs. This will be implemented by using the proposed health insurance limit starting January 1, 2027, in the rate setting calculation.

This proposal seeks to address the issue of lack of cost containment by limiting reimbursement for health insurance. In doing so, facilities will need to be more prudent about purchasing health insurance by regularly seeking quotes from multiple commercial products and/or purchasing adequate stop-loss insurance.

Increasing Quality in Nursing Facility Care

This proposal will change the formula for the quality-based limit in VBR to ensure that the original intention of VBR is fulfilled. This proposal changes the computation of the reimbursement limit for care-related costs within the VBR rate setting formula to create a stronger quality incentive while at the same time reward cost efficiencies. The rate decrease will be specific to facilities but will be an average decrease per resident day of $7.06 for CY 2027, $7.43 for CY 2028, and $7.87 for CY 2029. These decreases will impact the Medicaid and private pay nursing facility rates effective on January 01, 2027, reimbursing affected providers the lower of actual or the limited care-related operating costs. This will be implemented by using the proposed quality-limit based formula starting January 1, 2027, in the rate setting calculation. This proposal seeks to address the issue of the VBR not meeting one of its main goals of incentivizing better quality of care through the Medicaid rate setting process. This change in the quality-based limit for care-related providers will reward facilities for improving the quality of life for residents in the nursing facility.

Fiscal Impact:
Below are the net costs for each of the components in the proposal.

Net Impact by Fund (dollars in thousands)	FY 26	FY 27	FY 28	FY 29
End PCRA's	0	(4,245)	(4,717)	(4,837)
Limit Health Insurance	0	(1,008)	(2,459)	(2,533)
PIPP Termination	0	(4,036)	(6,033)	(7,525)
Care Related Quality Limit Change	0	(5,648)	(13,938)	(14,759)
Total All Funds	**0**	**(14,937)**	**(27,146)**	**(29,654)**

Dollars in Thousands

Net Impact by Fund (dollars in thousands)			FY 26	FY 27	FY 26-27	FY 28	FY 29	FY 28 - 29
General Fund			0	(14,937)	(14,937)	(27,146)	(29,654)	(56,800)
HCAF			0	0	0	0	0	0
Federal TANF			0	0	0	0	0	0
Other Fund			0	0	0	0	0	0
Total all Funds			**0**	**(14,937)**	**(14,937)**	**(27,146)**	**(29,654)**	**(56,800)**
Fund	**BACT#**	**Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28 - 29**
GF	33	MA NF Pymnt Sys - End PCRA's	0	(3,991)	(3,991)	(4,426)	(4,529)	(8,955)
GF	33	Managed Care - End PCRA's	0	(254)	(254)	(291)	(308)	(599)
GF	33	MA NF Pymnt Sys - Limit Health Insurance	0	(948)	(948)	(2,307)	(2,372)	(4,679)
GF	33	Managed Care - Limit Health Insurance	0	(60)	(60)	(152)	(161)	(313)
GF	33	MA NF Pymnt Sys - PIPP Termination	0	(3,795)	(3,795)	(5,661)	(7,045)	(12,706)
GF	33	Managed Care - PIPP Termination	0	(241)	(241)	(372)	(480)	(851)
GF	33	MA NF Pymnt Sys - Care Related Quality Change	0	(5,310)	(5,310)	(13,079)	(13,818)	(26,897)
GF	33	Managed Care - Care Related Quality Change	0	(338)	(338)	(859)	(941)	(1,800)

Impact on Children and Families:
These proposals do not have a direct impact on children and families, however reduced nursing home rates will impact all families in Minnesota that have loved ones in impacted nursing homes as rates will be reduced for all Minnesota residents who pay for nursing homes in those facilities, not just for services funded through Medicaid. This proposal also intends to increase the quality of care, impacting families with loved ones in nursing homes.

Equity and Inclusion:
These proposals will not disproportionately impact any community or population. All Medicaid-certified nursing facilities, and all people whose stays are paid by Medicaid or who pay privately will be affected to some extent. The proposals may have an overall positive effect for people who need facility care and their families, as they would reduce costs in the average facility with the goal of maintaining access and quality. DHS staff will continue to provide quality improvement support to nursing facilities and to reward improvement through the Quality Improvement Incentive Payment program.

As nursing facility operators and staff would be the most affected, we will provide communication with nursing facility quality councils comprised of trade organization staff, providers, quality improvement organization staff, and other interested parties on a semiannual basis or as requested.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
This proposal will have a low to medium impact on counties in the form of savings, due to counties paying a share of nursing home costs. This proposal does not require county involvement in oversight, operations, or administration. Rates of disparities will not be impacted disproportionately in any county.

IT Costs:
There are no IT costs associated with this proposal.

Results:
Part A: Performance Measures
The overall goal is to bring integrity to the Medicaid program by paying for costs only once, while also improving the effectiveness of the VBR quality limit and eliminating outdated rate programs. The expected outcomes are cost savings in reimbursement to nursing facilities starting on July 1, 2026, with maintenance of the quality score, and a reduction in annual bed closures realized after the first full year of implementation of these changes.

Measure	Measure type	Measure data source	Most recent data	Projected change
Number of nursing home beds closed annually	*Quantity*	Annual average for over the past three SFY	*511*	Fewer nursing home beds will be taken out of service annually.
The state-wide average quality score	Quality	The average quality scores of individual facilities	72.93	Maintain or increase state-wide average quality score

Measure	Measure type	Measure data source	Most recent data	Projected change
Cost of Health Insurance	Quantity	Average cost of Health Insurance per enrollee	9,700	Slow the projected growth of Health Insurance costs

Part B: Use of Evidence

1. Have you previously conducted a formal quantitative or qualitative program evaluation that informed the contents of this proposal? If so, please briefly describe the evaluation.

   Yes, a former evaluation of the current Quality-based limit methodology was performed the results can be found here.

2. Are you planning to conduct a formal qualitative or quantitative program evaluation related to this proposal? Indicate what kind(s) of evaluation you will be conducting. Select all that apply.

   _X_ No formal evaluation planned at this time
   __ Not yet determined
   __ Needs Assessment
   __ Process or Implementation Evaluation
   __ Summative Impact Evaluation(Randomized Control Trial(RCT) or Quasi-Experimental Design)
   __ Summative Evaluation other than an Impact Evaluation
   __ Other (please describe or link):

Part C: Evidence-Based Practices

If applicable, provide the following information on the evidence-based practices supported by the change item. The Results Team at MMB reviews change items to identify the proposals and agencies that support evidence-based practices. The definitions of evidence used by Results Management are available at https://mn.gov/mmb/results-first/definitions-of-evidence/. Resources to find evidence-based practices are available at https://mn.gov/mmb/evidence/finding/.

Evidence-based practice:	Source:
N/A	*N/A*

Department of Human Services
FY 2026-27 Biennial Budget Change Item

Change Item Title: OIG Increased Fines and Licensor Safety (IG-27)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	0	0	0
Revenues	0	(19)	(19)	(19)
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	(19)	(19)	(19)
FTEs	**0**	**0**	**0**	**0**

Request:

The Governor recommends enhancing the Department of Human Services' (DHS) accountability measures by increasing fines for health and safety violations as well as implementing additional enforcement mechanisms for threatening or abusive behavior toward staff.

In recent years, staff have faced threats, harassment, and property damage while carrying out their oversight duties. Stronger accountability measures for license holders who engage in these aggressive, threatening, or violent behaviors toward staff that conduct oversight of licensed programs is needed.

Moreover, DHS requires stronger enforcement tools for use with license holders who violate health, safety, supervision, or background study requirements. Specifically, this proposal would increase the fine for license holders who violate health, safety, supervision, or background study requirements from $200 to $500. It would also increase fines for other licensing violations from the current fine amount of $100 to $300.

Raising the fine levels for health, safety, supervision or background studies, and adding enforcement mechanisms for abusive or threatening behaviors does not require additional state resources. The proposal is expected to generate approximately $19,200 more annually through higher licensing fines.

Rationale/Background:

The proposed changes are designed to increase accountability for license holders who engage in threats, harassment, or violence toward DHS staff, and reduce the frequency of and ideally eliminate incidents. Unfortunately, threats against public officials and public servants have become all too common. Staff, responsible for conducting oversight at licensed programs, have reported threatening behavior and property damage while carrying out their duties. These incidents create unsafe working conditions. Current enforcement tools are limited to the requirements of the license and therefore not sufficient to deter or address aggressive conduct directed at state employees while they perform their job responsibilities.

Similarly, the DHS would benefit from more robust compliance mechanisms in its ability to respond to provider violations. The current options for corrective action could be more effective for violations of health, safety, supervision or background study requirements, including providing false or misleading information. When these situations do not warrant the strongest sanctions, such as license revocation, the department may issue a fine. Fines for health, safety, supervision, or background study violations are capped at $200. A fine of $100 may be issued for other instances of noncompliance with licensing standards. Neither of these amounts are sufficient to encourage corrective action.

Proposal:

This proposal increases current fine amounts for noncompliance with DHS licensing requirements, and in effect, raises the overall standard of compliance to help safeguard vulnerable populations. It also adds the ability to impose a fine or take other actions on a license in response to threats, intimidation or violence towards DHS staff. This proposal also complements the broader program integrity efforts underway at DHS. No new appropriations are requested as the authority and ability to levy fines already exists.

Higher Licensing Fines

This proposal is expected to generate approximately $19,200 more annually through higher licensing fines.

Imposing a fine or other actions in response to threats, intimidation or violence

The portion of this proposal that adds authority to impose a fine or take other actions on a license in response to threats, intimidation, or violence towards DHS staff is budget neutral in this proposal. The potential revenue from fines on threatening or abusive behaviors cannot be calculated because DHS does not have data currently to project the anticipated additional revenue.

Overall, this proposal enhances program integrity by creating a more effective and proportionate enforcement system that improves compliance, protects vulnerable populations, and strengthens oversight across DHS programs.

Fiscal Impact

This proposal is expected to generate additional fee revenue through increased fines, while requiring no new general fund appropriations. The primary fiscal impact is associated with increased collections from fines imposed on license holders who fail to comply with health, safety, supervision, or background study requirements.

Key assumptions underlying the fiscal estimates include historical fine data and projected compliance patterns. From calendar years 2022 to 2024, an average of 64 fines per year were issued under existing licensing standards, each at $200. By increasing this fine to $500, DHS estimates approximately $19,000 in additional annual revenue from licensing violations.

The proposal assumes no additional full-time staff are required; the proposal leverages existing FTEs in the Office of the Inspector General.

The increase in revenue based on levying the proposed fines for aggressive or threatening behavior is not currently calculable because to date the department has not tracked behaviors that would lead to these fines.

Dollars in Thousands

Net Impact by Fund			FY 25	FY 26	FY 27	FY 25-27	FY 28	FY 29	FY 28-29
General Fund				0	(19)	(19)	(19)	(19)	(38)
Other Fund 1									
Other Fund 2									
		Total All Funds		0	(19)	(19)	(19)	(19)	(38)
Fund	**BACT**	**Description**	**FY 25**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	REV2	Increased Fines		0	(19)	(19)	(19)	(19)	(38)

Requested FTEs									
Fund	**BACT**	**Description**	**FY 25**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
				0	0	0	0	0	0

Impact on Children and Families:

This proposal contributes to the safety of children and other vulnerable individuals served by DHS-licensed programs by providing the department the ability to hold license holders accountable for threatening and violent behavior. This proposal also promotes compliance with health, safety, and supervision requirements, including background study requirements. As a whole, this proposal protects the health, safety, and wellbeing of vulnerable adults and children by increasing the incentive to be in compliance with licensing requirements.

Equity and Inclusion:

Along with utilizing the DHS Equity Policy and Toolkit to advance our equity goals, DHS will continue to practice a participatory approach to community engagement. We will evaluate policies and implementation regularly to continuously identify opportunities for improvement. Ultimately, this proposal will protect the vulnerable adults and children who received DHS-licensed services. People receiving services represent communities of varying ages, races, and ability levels.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:

This proposal would protect county staff who perform licensing functions through delegated authority from threats and abuse. This proposal will not have an impact on counties financially. It will not result in increased expenditures, or savings.

IT Costs:

There are no IT costs associated with this proposal.

Results:

Part A: Performance Measures

8. The overall goal of this proposal is to strengthen protections for licensors and investigators who face threatening or aggressive behavior while conducting oversight at licensed programs. The expected outcome is that staff will be able to complete oversight responsibilities safely and effectively, with reduced incidents of harassment, intimidation, or property damage. This change item will be considered successful if the number of reported threats and aggressive incidents decreases in a relatively short amount of time and staff report feeling safer when conducting site visits.
9. Evidence supporting the proposal is two-fold. First, staff have reported threatening behaviors and property damage during licensing inspections. Second, an average of 64 fines per year were issued under current licensing rules for violations of health, safety, supervision or background studies, suggesting both a need and opportunity for more effective enforcement.
10. Success will be reflected in fewer reports of threatening behavior, and improved staff confidence in their ability to carry out oversight duties. A decrease in fines over time will be evidence that the increased fine levels worked to improve compliance.

Measure	Measure type	Measure data source	Most recent data	Projected change
Revenue from the new level of fines.	*Increased Revenue*	*Increase in revenue.*	*$12,800 in CY 2024*	*On average, 64 of these fines for health, safety, supervision and background studies are levied a year. There should be a corresponding jump in fine revenue based on the higher fine level.*
Possible decrease in fines levied.	Fines levied after higher fines take effect.	Fines levied by the department for violations.	64 per year on average.	If the higher fines have a deterrent effect, then after the new levels of fines are applied, there should be a reduction in the number of fines levied.

Part B: Use of Evidence

9. Have you previously conducted a formal quantitative or qualitative program evaluation that informed the contents of this proposal? If so, please briefly describe the evaluation. No.
10. Are you planning to conduct a formal qualitative or quantitative program evaluation related to this proposal? Indicate what kind(s) of evaluation you will be conducting. Select all that apply.

X No formal evaluation planned at this time
__ Not yet determined
__ Needs Assessment
__ Process or Implementation Evaluation
__ Summative Impact Evaluation (Randomized Control Trial (RCT) or Quasi-Experimental Design)
__ Summative Evaluation other than an Impact Evaluation
__ Other (please describe or link):

Statutory Change(s):

Adding a section: 245A.XX Licensee Conduct Toward Public Officials

245A.07, subd. 3, paragraph (c), clause (4), items (iii) and (iv)

Department of Human Services
FY 2026-27 Biennial Budget Change Item

Change Item Title: Federal Compliance: Access to Services for Incarcerated Individuals (BH-45)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	178	946	2,077
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	178	946	2,077
FTEs	**0**	**0**	**5**	**5**

Request:

The Governor recommends investments that support the successful reentry of incarcerated individuals into their communities. This initiative aims to enhance public safety and ensure equitable behavioral health outcomes by creating a carceral pre- and post-release case management benefit set. In addition, this proposal also aims to comply with federal law providing screening and targeted case management services to juveniles in carceral settings for 30 days prior to release and at least 30 days post release. Both adult and juvenile services will provide coordinated supports during the highest-risk periods before and after release, helping to bridge the gap between incarceration and community stability.

Recent Minnesota data crystalizes the urgency of this proposal:

- Among individuals released from Minnesota jails, the age- and gender-adjusted rate of overdose death is estimated to be 15.5 times higher than that of the general Minnesota population; for those released from state prisons, the rate skyrockets to 28.3 times higher[1][2].
- Substance use is the leading cause of death for individuals reentering from jail (35.9% of post-release deaths) and prison (33.1%), compared to just 1.7% in the general population[3],[4].
- Overall, the risk of death following release—regardless of cause—is more than 10-fold higher than for the general population in Minnesota[5],[6].

These stark disparities underscore the need for carefully structured, pre-emptive, and extended support systems to bridge the gap between incarceration and community stability.

[1] Hill, Katherine & Bodurtha, Peter & Winkelman, Tyler & Howell, Benjamin. (2024). Postrelease Risk of Overdose and All-Cause Death Among Persons Released From Jail or Prison: Minnesota, March 2020-December 2021. American journal of public health. 114. e1-e10. 10.2105/AJPH.2024.307723.

[2] Hill K, Bodurtha PJ, Winkelman TNA, Howell BA. Postrelease Risk of Overdose and All-Cause Death Among Persons Released From Jail or Prison: Minnesota, March 2020-December 2021. Am J Public Health. 2024 Sep;114(9):913-922. doi: 10.2105/AJPH.2024.307723. Epub 2024 Jul 18. PMID: 39024534; PMCID: PMC11306622.

[3] https://medicine.yale.edu/news-article/cause-of-death-after-prison-release-differs-from-general-population/

[4] https://www.hhrinstitute.org/cause-of-death-after-prison-release-differs-from-general-population/

[5] https://medicine.yale.edu/news-article/cause-of-death-after-prison-release-differs-from-general-population/

[6] https://www.hhrinstitute.org/cause-of-death-after-prison-release-differs-from-general-population/

Rationale/Background:

Reentry for Adults:
The 2024 legislature authorized Minnesota to implement a Medicaid 1115 demonstration waiver to support MA-eligible populations in jails and prisons, 90 days prior to release. This proposal supports implementation of that effort.

Currently, Minnesota lacks a defined Medicaid benefit set for coordinated case management during the critical transition from incarceration to community. Individuals leaving correctional facilities experience significantly elevated health risks. Without structured supports, many reentering individuals face interrupted care, medication discontinuity, and unmet housing and behavioral health needs, which fuels preventable deaths, health inequities, and recidivism.

This proposal reduces preventable overdose and suicide deaths, improves continuity of care by linking people to benefits and providers before release, advances racial equity for Minnesotans disproportionately impacted by incarceration, and strengthens public safety by supporting successful reentry.

It reflects the priorities of the Reentry Services Work Group and aligns with Minnesota's 1115 Reentry Demonstration application, ensuring state resources complement federal funding to deliver coordinated pre- and post-release carceral case management. By enhancing program integrity through timely and accurate data-sharing on incarceration status, the state can prevent improper eligibility determinations, reduce gaps in Medicaid coverage, and ensure that individuals are enrolled in the right services at the right time. Reliable data exchange strengthens fiscal accountability and helps Minnesota safeguard both state and federal dollars while delivering high-quality, compliant reentry services.

Reentry for Incarcerated Youth:
Section 5121 of the Consolidated Appropriations Act (CAA) of 2023 mandates a new Medicaid service for youth in carceral settings. Currently, when an individual enrolled in Medical Assistance (MA) becomes incarcerated, they remain eligible for MA, but their health care benefits are limited to in-patient hospitalization services only.

Section 5121 mandates that states provide screening and diagnostic services that meet reasonable standards of medical and dental care, or as otherwise indicated as medically necessary, in accordance with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, including a behavioral health screening or diagnostic services. These services were to begin January 1, 2025, and include certain screening, diagnostic, and case management services to eligible youth in carceral settings. The services mandated by Section 5121 of the CAA must be provided in the 30 days prior to release and the 30 days post release, with the option for states to extend services to 180 days following release or until the service plan is completed.

Carceral reentry case management is a targeted service designed to meet federal case management standards. The benefit includes 30 days of pre-release coverage and up to six-months, or 70 units per episode, of post-release services. Individuals may receive mental health, substance use, and medical screenings, diagnostic or functional assessments, developing individualized service plans, facilitating referrals to mental health, medical, educational, social, or other supportive services, ensuring coordination of services, and monitoring the completion of services outlined in the plan. These services are tailored to support individuals transitioning from incarceration who have complex physical or behavioral health needs, helping them access the resources necessary for successful reintegration into the community.

Eligible juveniles under this proposal include youth under 21 years of age who are eligible for MA under a Child basis, or youth under age 26 who are eligible for MA under the Former Foster Care Child basis. Carceral settings include state prisons, local jails, Tribal jails and prisons, and juvenile detention and youth correctional facilities. This does not include federal prisons.

Proposal:

Reentry for Adults:
The original statute established requirements for reentry services but did not create or fund a dedicated carceral case management benefit set to cover coordinated pre- and post-release supports. This proposal closes that gap by establishing a new Medicaid benefit set. Under this proposal, adults may receive up to 70 units per episode of carceral reentry case management post-release, which includes assessments, service planning, coordination with behavioral health and housing providers, and ongoing monitoring. Pre-release case management for adults has already been factored into the forecast and is not limited by units but rather a 90-day pre-release eligibility period. The unit cap post-release ensures a standardized service structure and allows individuals to access services as they are needed. Some individuals may need more support initially while others may need more support as time goes on. This person-centered approach addresses overdose and suicide risks, ensures continuity of care, and strengthens public safety through successful reentry.

Administrative/Programmatic Capacity: Funding will support DHS in creating and overseeing the benefit set, including 1 FTE dedicated to program administration, training, and quality oversight. This will ensure consistent provider credentialing, fidelity to evidence-based practices, and improved client outcomes.

Equipment/Supplies: Limited funding will support IT and data integration costs (e.g., secure servers, licenses, and interoperability tools) necessary to exchange data between DHS, the Department of Corrections (DOC), and local jails. This infrastructure will enable real-time eligibility determination and care coordination.

Forecasted Programs: Approximately 5,000–6,000 individuals annually are released from Minnesota state prisons and an estimated 100,000 annually cycle through county jails. This proposal will impact a subset of those at highest risk of overdose, suicide, or acute behavioral health needs by providing up to six-months of pre-release services including 70 units per episode of carceral reentry case management, which includes assessments, service planning, coordination with behavioral health and housing providers, and ongoing monitoring.

This proposal complements work led by the Reentry Services Work Group, which includes DHS, DOC, county partners, and tribal governments. It aligns with DOC's reentry planning initiatives, the Behavioral Health Division's efforts to expand substance use and mental health services, and Minnesota IT Services (MNIT) infrastructure modernization projects.

This proposal directly addresses the problems outlined in the Rationale section: elevated risk of overdose and suicide among justice-involved individuals during the immediate post-release period. By establishing a pre- and post-release carceral case management benefit set, Minnesota will reduce preventable deaths, improve health outcomes, and strengthen public safety.

Implementation Timeline

- Effective Date: January 2028 pending CMS approval
- Implementation Steps:
    1. Develop DHS rules, provider guidance, and contracts for grant administration (FY26–27).
    2. Build IT/data infrastructure and ensure interoperability with DOC and local jails.
    3. Train providers on Medicaid eligibility, care coordination, overdose and suicide prevention protocols.
    4. Launch benefit set statewide, beginning with DOC, demonstration counties and tribal facilities.

5. Conduct monthly monitoring and evaluation in partnership with the Reentry Services Work Group.

Reentry for Incarcerated Youth

This proposal aims to develop and implement the screening and targeted case management services mandated by Section 5121 of the CAA. Data from DHS reveals that only 36% of 15- to 18-year-olds and 20% of 19- to 20-year-olds receive their annual recommended preventative health visits. This proposal seeks to address this gap by not only providing the mandated screening but also providing a comprehensive preventative visit in accordance with pediatric best practice.

Section 5121 of the CAA explicitly requires states to ensure that all eligible juveniles receive the screening and case management services. To comply with this federal requirement, DHS will implement a carceral reentry targeted case management benefit similar to or same as the 1115 Reentry Demonstration carceral case managed benefit.

Because these services are MA-reimbursable, carceral settings wishing to use their own staff or contract with a provider directly to deliver the required services may do so.

This proposal also removes the requirement from the 1115 Reentry Demonstration Waiver to include juvenile justice facilities, as juveniles in those carceral settings will now be receiving screening and case management services under Section 5121 of the CAA.

Implementation of this proposal would require changes to Minnesota statutes and a Medicaid State Plan Amendment. The effective date of this proposal is January 1, 2028.

This proposal will require 4 FTEs to implement:

- One FTE to serve as the eligibility policy expert who will analyze Medicaid eligibility requirements and develop, implement, support, and maintain eligibility policies for this population
- One FTE is responsible for training and education of health care eligibility workers at processing entities
- One FTE responsible for provider training
- Two FTEs in Medicaid payments and provider services, responsible for operations, payment, and program integrity functions

Fiscal Impact

Net Impact by Fund (dollars in thousands)			FY 26	FY 27	FY 26-27	FY 28	FY 29	FY 28-29
General Fund			-	178	178	946	2,077	3,023
		Total All Funds	-	178	178	946	2,077	3,023
Fund	**BACT**	**Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	33	MA Program Impacts	-	-	-	329	1,505	1,834
GF	13	HCA Admin (0,0,2,2)	-	-	-	381	346	727
GF	11	HCA Admin (0,0,2,2)	-	-	-	103	93	196
GF	15	BHA Admin (0,0,1,1)	-	-	-	203	186	389
GF	15	BHA Admin Evaluation Contracts	-	150	150	150	150	300
GF	11	System Impacts (Mets, SMI, Maxis, MMIS)	-	76	76	15	15	30
GF	REV1	Admin/Contract FFP @ 32%	-	(48)	(48)	(235)	(218)	(453)
FTE Descriptions								
Fund	**BACT**	**Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	13	HCA Admin (0, 0, 2, 2)		0	0	2	2	2
GF	11	HCA Admin (0, 0, 2, 2)		0	0	2	2	2
GF	15	BHA Admin (0, 0, 1, 1)		0	0	1	1	1

Impact on Children and Families:

Reentry for Adults

In Minnesota, parental incarceration is a widespread challenge with lasting impacts on children and families. The 2022 Minnesota Student Survey found that approximately 13% of students reported having a currently or previously incarcerated parent or guardian[7][8]. The prevalence is even higher outside the metro: in Greater Minnesota, 15–22% of 8th, 9th, and 11th graders reported parental incarceration compared to 10% of metro students[9]. Nearly two-thirds of adults in Minnesota jails are parents of minor children, and most lived with their children prior to arrest, underscoring the destabilizing effect incarceration has on family life[10]. Parental incarceration disrupts child development, contributes to adverse educational and social outcomes, and creates instability that can persist across generations. Coordinated supports during reentry—spanning health care, behavioral health, benefits, and housing—offer a critical opportunity to interrupt this cycle and improve outcomes for children.

These challenges are compounded by stark inequities in who is most impacted by incarceration. Native American women, for example, represent roughly 20% of the incarcerated female population at MCF–Shakopee, despite making up only about 1% of Minnesota's overall population[11], [12]. Many of these women have histories of violence, abuse, and trauma, which further amplifies the intergenerational impact on children and families. This disproportionate representation highlights the urgent need for culturally responsive, trauma-informed reentry services that support parents in resuming their caregiving roles and promote stability for the next generation.

Reentry for Incarcerated Youth

The current juvenile justice system is not equipped to meet the health or behavioral needs of incarcerated youth. Incarceration during adolescence and early adulthood is associated with worse physical and mental health in adulthood, as well as an increased risk of recidivism.[13]

Many youth in carceral settings have significant health care needs, with high rates of tuberculosis, dental problems, and sexually transmitted infections such as HIV.[14] Additionally, approximately two-thirds of justice-involved youth have a diagnosable mental health condition or substance use disorder.[15]

Untreated behavioral health needs for youth contribute to the likelihood of future offenses, which require the juvenile justice system to not only address rehabilitation, but also screening, assessment, and referral for behavioral health needs.[16] Appropriate screening and referral leads to treatment, and early treatment of youth

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[7] https://www.health.state.mn.us/data/mchs/surveys/mss/docs/statewidetables/MENA_Single22.pdf?

[8] https://www.health.state.mn.us/news/pressrel/2023/incarceration032823.html

[9] https://content.govdelivery.com/accounts/MNMDH/bulletins/351869c

[10] https://www.cbsnews.com/minnesota/news/project-seeks-to-support-minnesota-children-with-incarcerated-parents/?

[11] https://www.mnhousing.gov/content/published/api/v1.1/assets/CONT439E324C3E6D4341BDA5759F0BE8A4BE/native?cb=_cache_eb76&channelToken=294436b7dd6c4570988cae88f0ee7c90&download=false&utm_

[12] https://www.health.state.mn.us/communities/practice/healthymnpartnership/narratives/docs/NarrIncarcerationInequities.pdf?

[13] Centers for Medicare and Medicaid Services, SHO #24-004 RE: Provision of Medicaid and CHIP Services to Incarcerated Youth, July 23, 2024, at pg. 6.

[14] Medicaid and CHIP Payment and Access Commission (MACPAC), Access in Brief: Health Care Needs and Use of Services by Adolescents Involved with the Juvenile Justice System, August 2021, pg. 1.

[15] MACPAC, Access in Brief, pg. 1.

[16] SHO#24-004, at pg. 7.

mental health and substance use disorders has been shown to effectively divert youth out of the justice system.[17] Thus, it is vitally important to support youth in carceral settings during this pivotal time, through screening and case management, to link them to the physical and mental health services necessary to help them succeed.

Equity and Inclusion:

Minnesota faces some of the nation's starkest racial and gender disparities in health and criminal justice outcomes. The state leads the nation in overdose mortality disparities between American Indians and whites and ranks second for disparities affecting African Americans. At the same time, Minnesota's criminal justice system shows some of the widest racial disparities in the country, despite relatively low overall incarceration rates. Between 2015 and 2017, Black Minnesotans were incarcerated at 4.7 to 9.1 times the rate of whites, while Native Americans were incarcerated at 11 to 14.3 times the rate of whites[18], [19]. These inequities ripple through families and communities, amplifying intergenerational harm. By embedding pre- and post-release case management into reentry, the proposal ensures more consistent access to behavioral health and substance use disorder services during the critical transition period.

The proposed benefit set is designed to counter these disparities by providing pre- and post-release carceral case management that is targeted and culturally responsive. Positive impacts will include more consistent behavioral health and social service coordination before release, smoother transitions to housing and social health benefits after release, and reduced risk of overdose and suicide during the critical pre- and post-release transition window. By embedding case management into reentry, the proposal also ensures more consistent access to behavioral health and substance use disorder services during this high-risk transition period. Potential challenges—such as distrust of systems, privacy concerns, or gaps in rural access—will be addressed through engagement of lived-experience peers, Black- and Tribal-led service design, and strong privacy protections.

Community voice and accountability are central to the case management model. The proposal has been shaped by the Reentry Services Work Group, Tribal partners, Black community-based organizations, lived experience councils, and local corrections and health leaders. DHS will maintain ongoing consultation and co-design processes, particularly with Tribal governments and Black-led providers, to ensure carceral case management services remain equitable, culturally grounded, and responsive to the needs of those most affected.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

This proposal incorporates guidance from ongoing Tribal consultation and the work of the Reentry Services Work Group. As part of implementation, DHS will prioritize the selection of a correctional pilot site owned and managed by a Tribal government or, alternatively, a facility located outside the seven-county metropolitan area with an inmate population that includes a significant proportion of Tribal members or American Indians.

Ongoing Tribal consultation on this proposal will continue as the proposal advances, the outcomes of that ongoing process will be incorporated directly into program design, site selection, and service delivery to ensure the benefit set reflects Tribal priorities and addresses the disproportionate impact of incarceration on American Indian communities.

[17] SHO#24-004, at pg. 8.
[18] https://50stateblueprint.aclu.org/assets/reports/SJ-Blueprint-MN.pdf?
[19] https://www.vera.org/publications/state-incarceration-trends/minnesota?

Impacts to Counties:
While counties have been strong advocates for the 1115 Reentry Demonstration, local jails will require significant technical assistance to implement effective pre- and post-release case management. The demonstration will begin in pilot sites, but its benefits extend far beyond—individuals released from correctional facilities will return to all 87 counties and the 11 federally recognized Tribal Nations, necessitating statewide support. To facilitate this, DHS will direct administrative resources toward training, IT integration, and operational support across diverse systems.

Selected county pilot sites will be awarded readiness funding established through Laws 2024, chapter 125[20], which authorizes capacity-building and implementation grants for MA (Medicaid) reentry demonstration facilities to prepare for delivering these services. This one-time investment helps counties build infrastructure, staff capacity, and data-sharing capabilities in preparation for launch.

County carceral settings are included as eligible facilities under the CAA. Any county carceral settings that holds an eligible youth would be required to comply with the requirements of Section 5121 of the CAA.

By leveraging Medicaid funding for these services, counties can align with broader policy goals, reduce uncompensated care, lower overdose and recidivism rates, and enhance local public safety and public health outcomes.

IT Costs:
Changes are required to METS, MMIS, MAXIS and SMI. Work estimate also includes the Department of Corrections (DOC) costs to work in collaboration with DHS.

Results:
The goal of this change item is to reduce preventable overdose and suicide deaths, improve continuity of care, and strengthen public safety by establishing a Medicaid benefit set for pre- and post-release case management. Success will be measured by increased linkage to care, improved continuity of Medicaid and behavioral health services, and measurable reductions in overdose and suicide within three years of implementation. Additionally, as required by CMS, an independent evaluator will develop a monitoring protocol. A mixed methods evaluation will draw on quantitative analysis to understand how the demonstration impacted key outcome measures, as well as qualitative analysis to gain insight into the effective of the waiver.

Evidence strongly supports the effectiveness of reentry planning and case management in reducing mortality and improving outcomes. A 2022 Minnesota-based study found that individuals released from jail faced a 15.5-fold higher risk of overdose death and those released from prison faced a 28.3-fold higher risk compared to the general population[21], [22]. National studies demonstrate that structured pre- and post-release case management—including Medicaid benefits activation, care coordination, and warm handoffs—reduce recidivism, increase treatment retention, and improve long-term health outcomes (SAMHSA, 2020)[23]. Minnesota's 1115 Reentry Demonstration application builds on this evidence by targeting the 90-day pre-release period, while this proposal extends supports into the post-release window when risks peak.

[20] https://www.house.mn.gov/hrd/as/93/as125.pdf?
[21] https://pubmed.ncbi.nlm.nih.gov/39024534/
[22] https://medicine.yale.edu/news-article/cause-of-death-after-prison-release-differs-from-general-population/
[23] https://library.samhsa.gov/sites/default/files/sma16-4998.pdf

Measure	Measure type	Measure data source	Most recent data	Projected change
% of individuals released with Medicaid active at release	*Quantity*	*DHS eligibility and MMIS data*	*Baseline: ~50% (estimated)*	*Increase to 85% within 3 years*
% of individuals linked to a behavioral health or primary care provider within 30 days post-release	Quality	DHS–DOC data exchange; county/Tribal provider reports	N/A (new measure)	Achieve 75% linkage within 3 years
Rate of overdose deaths within 90 days post-release	Result	MN Department of Health mortality data matched to DOC release records	Baseline: 15.5x (jail) / 28.3x (prison) higher than general population	Reduce by 25% over 2 years

Qualitative Measures

- Narrative feedback from individuals receiving case management (focus groups, structured interviews).
- Provider feedback on system coordination, data exchange, and service delivery challenges.
- County and Tribal partner reports on implementation experience.

If successful, qualitative data will show improved trust in reentry supports, greater cultural responsiveness, and stronger collaboration between DHS, DOC, counties, and Tribal governments.

Part B: Use of Evidence

11. Have you previously conducted a formal quantitative or qualitative program evaluation that informed the contents of this proposal? If so, please briefly describe the evaluation.

    Minnesota has not conducted a formal statewide evaluation of pre- and post-release case management. However, national evaluations (e.g., Bureau of Justice Assistance's "Second Chance Act" programs) and peer-reviewed research consistently demonstrate reduced recidivism and mortality when structured reentry supports are provided. The state's 1115 Reentry Demonstration application was informed by this body of evidence.

12. Are you planning to conduct a formal qualitative or quantitative program evaluation related to this proposal? Indicate what kind(s) of evaluation you will be conducting. Select all that apply.

    __ No formal evaluation planned at this time
    __ Not yet determined
    __ Needs Assessment
    X Process or Implementation Evaluation
    X Summative Impact Evaluation (Randomized Control Trial (RCT) or Quasi-Experimental Design)
    __ Summative Evaluation other than an Impact Evaluation
    __ Other (please describe or link):

Part C: Evidence-Based Practices

If applicable, provide the following information on the evidence-based practices supported by the change item. The Results Team at MMB reviews change items to identify the proposals and agencies that support evidence-based practices. The definitions of evidence used by Results Management are available at

https://mn.gov/mmb/results-first/definitions-of-evidence/. Resources to find evidence-based practices are available at https://mn.gov/mmb/evidence/finding/.

Evidence-based practice:	**Source:**
List the names of program or activity that are evidence-based and directly funded by this change item.	*Provide a link to the clearinghouse or journal article that establishes the evidence for this change item.*
Pre- and post-release case management (targeted case management, benefits activation, and coordinated warm handoffs)	Wakeman, S.E., et al. (2022). *Postrelease Risk of Overdose and All-Cause Death Among Persons Released From Jail or Prison: Minnesota, March 2020–December 2021. American Journal of Public Health.*[24] SAMHSA (2020). *Guidelines for Successful Transition of People with Behavioral Health Disorders from Jail and Prison.*[25] Bureau of Justice Assistance. *Second Chance Act Evaluation.*[26]

Statutory Change(s):
256B.0625 and 256B.0761

[24] https://pubmed.ncbi.nlm.nih.gov/35943608/
[25] https://library.samhsa.gov/product/Guidelines-for-Successful-Transition-of-People-with-Behavioral-Health-Disorders-from-Jail-and-Prison/PEP20-02-01-001?
[26] https://bja.ojp.gov/program/second-chance-act/reentry-programs?

Department of Human Services
FY 2026-27 Biennial Budget Change Item

Change Item Title: Increasing Mental Health Supports: Coordinated Specialty Care Medicaid Benefit (BH-51)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	332	3,948	4,682
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	332	3,948	4,682
FTEs	**0**	**0.75**	**2**	**2**

Request:

The Governor recommends development of a new Medical Assistance benefit called Coordinated Specialty Care to ensure individuals experiencing early episodes of psychosis can access person-centered and evidence-based care to support their mental health needs.

Coordinated specialty care (CSC) is the standard of care for treatment of First Episode Psychosis (FEP). It is an evidence-based, recovery-focused, team-based model that promotes access to care and shared decision-making among specialists, the person experiencing psychosis, and family members.

Several of the services included in CSC are existing services in Minnesota and are billable to Medical Assistance as separate services. Existing state and federal grant funds support payment of services that are not covered by Medical Assistance. This proposal recommends defining a new service that includes specific requirements for a single bundled rate. By including Medical Assistance coverage for this set of services, state Medicaid funds would be matched by federal Medicaid funds, offsetting current state funding and providing high quality care to Minnesotans in need.

Rationale/Background:

Three out of one hundred people will experience an episode of psychosis. Symptoms of psychosis can be debilitating and the longer they are left untreated, the less likely an individual will experience recovery or reduced symptoms. This is why early intervention for someone experiencing psychosis is critical and life changing. Coordinated Specialty Care (CSC) is a multidisciplinary, evidenced based early intervention for individuals who have a recent onset of psychosis. Those who receive CSC services within the first couple years of experiencing an episode of psychosis will see improvements in areas like reduced stays in the hospital, ER visits and criminal justice involvement. They also have more success within occupational, educational and social settings and experience overall reduction in mental health symptoms.

CSC has proven highly effective at reducing hospitalizations, improving education and employment rates, improving social connections and relationships and reducing symptoms of psychosis. Patients participating in CSC are more likely to stay engaged in treatment and to experience a higher quality of life. Some people who receive early treatment may never experience another psychotic episode. For other people, recovery means the ability to live a fulfilling and productive life while managing ongoing symptoms.

CSC is provided by a multidisciplinary team that includes collaboration with an individual's other providers or supports. CSC includes the following components, and individuals are provided with a combination of one or more of these components, consistent with the needs of the individual:

- Assessment
- Crisis intervention
- Medication management
- Supported Employment and Education services
- Peer support services
- Case management
- Family peer support services
- Therapy - individual, family and group
- Treatment Planning
- Family psychoeducation

Current CSC providers, as well as community stakeholders and many workgroups, have voiced the need for the creation of a Medicaid benefit for CSC.

Proposal:

This proposal aims to create a Medicaid benefit for Coordinated Specialty Care in Minnesota.

Currently, Coordinated Specialty Care (CSC) teams in Minnesota are relying largely on grant funds, which limit the number of providers able to offer this treatment and carries risks of future loss of funding. Creating a Medicaid benefit for this service line is necessary to ensure it is accessible throughout the state of Minnesota. The development of this benefit would increase the number of individuals current teams are able to serve, as well as allow new providers throughout the state to begin offering CSC services in their geographic area with a sustainable funding source.

Creating a CSC Medicaid benefit would consolidate several related services into a single bundled benefit, making it easier for the state to monitor who is providing services, what services are being delivered, and which members are receiving care. Rather than tracking multiple service codes across different providers, DHS would oversee CSC services at the team level. This streamlined approach supports clearer billing practices, reduces duplication, and improves the state's ability to monitor service use and costs.

To enhance program integrity, the CSC Medicaid benefit would be subject to defined standards, monitoring, and enforcement mechanisms. DHS will establish a certification process with clear requirements for staffing, training, and service delivery based on the CSC model. Periodic fidelity reviews and recertification will help ensure services remain high quality and support consistent oversight and monitoring. DHS would also have the authority to conduct audits, require corrective actions, and take enforcement steps, including suspension and decertification.

Developing a Medicaid benefit for CSC would increase access to high-quality, evidence-based care, maximize the use of federal funds, and strengthen overall program integrity.

Fiscal Impact

Net Impact by Fund (dollars in thousands)	FY 26	FY 27	FY 26-27	FY 28	FY 29	FY 28-29
General Fund	-	332	332	3,948	4,682	8,631
HCAF						
Federal TANF						
Other Fund						
Total All Funds	-	332	332	3,948	4,682	8,631

Fund	BACT#	Description	FY 26	FY 27	FY 26-27	FY 28	FY 29	FY 28-29
GF	33	MA AD	-	-	-	526	648	1,175
GF	33	MA ED	-	-	-	1,769	2,180	3,949
GF	33	MA FC	-	-	-	1,208	1,489	2,697
GF	11	MMIS Systems (@29% State Share)	-	39	39	8	8	16
GF	11	MPSE Systems (@50% State Share)	-	9	9	2	2	4
GF	15	BHA Admin (0, 0.75, 2, 2)	-	168	168	390	372	762
GF	15	BHA Contracts (Provider Training, Capacity Building, Outcome Reporting)	-	250	250	250	150	400
GF	REV1	Admin FFP @ 32%	-	(134)	(134)	(205)	(167)	(372)
Fund	**BACT#**	**FTEs Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	15	BHA FTE (0,.75, 2, 2)	0	0.75	0.75	2	2	2

Impact on Children and Families:

Coordinated Specialty Care provided throughout the state of Minnesota will allow more opportunities for individuals and their families to have access to important and life-changing treatment, regardless of geographic location because it will increase the number of agencies able to provide these services in the state.

Data shows that individuals who receive Coordinated Specialty Care when experiencing an early episode of psychosis, will experience overall improved quality of life for them and their families. A reduction in hospitalizations, criminal justice involvement and overall mental health symptoms is observed in those who receive early intervention. Research has consistently shown that reducing the duration of untreated psychosis will have a positive effect on the response to treatment, and families will be more likely to receive these services when they exist in the community in which they reside. CSC places a strong emphasis regarding family and close supports being actively involved in treatment, and services are offered to family members of individuals being served, such as family peer support as well as family therapy.

Equity and Inclusion:

Black/African Americans, Native Americans and individuals in the LGBTQ community are shown to experience an increased risk of mental health challenges, such as psychosis, as well as increased barriers to accessing needed mental health services. By increasing the number of CSC providers across the state, more individuals are likely to access care. Coordinated Specialty Care teams work closely within the communities where they provide services to ensure culturally competent and inclusive care is provided.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

This proposed change has the potential to impact all Minnesota Tribal governments, because it could potentially increase mental health services in their geographic location. As more Minnesota Tribal governments see individuals receiving CSC, they are expected to see a decrease in symptoms of psychosis and individuals with untreated symptoms of mental illness.

Impacts to Counties:

When more individuals throughout the state have access to Coordinated Specialty Care, counties would see a positive impact. When early intervention takes place for an individual experiencing psychosis, the county would

see less of a burden on county resources since individuals experience less homelessness, and less criminal justice involvement when early intervention takes place.

IT Costs

These systems changes are estimated to require 1,197 hours of work, take approximately 10 months to complete, and cost a total of $152,536 (without FFP) for initial development.

Results:

Part A: Performance Measures

11. It is expected to be able to serve more FEP clients across the state and measure the fidelity of the teams that are providing these services to ensure the evidence-based practice is being followed. Fidelity measurement tools, such as the FEP-FS, is widely used to assess the quality of service and adherence to Coordinated Specialty Care teams to the evidenced based model. Ongoing fidelity reviews would be conducted as part of the ongoing certification process and would occur once or twice annually. Clients receive services on these teams for up to 2 years, so immediate data would be available on case load size, units of service, diagnosis, etc. Data points such as reason for discharge or ongoing maintenance of symptoms would take a few years of collection before notable changes could be seen.
12. Coordinated Specialty Care for psychosis was developed following the launch of the National Institute of Mental Health's Recovery After an Initial Schizophrenia Episode (RAISE) Project.

Measure	Measure type	Measure data source	Most recent data	Projected change
Monthly Caseload size by team – usually requested from us as a client total by year	Quantity	Currently monthly or quarterly reports	5 FEP teams served 310 clients in 2024	More clients accessing CSC services each year
Discharges + reason	Quantity and result	Currently monthly or quarterly reports		
Number of contacts per team member for each client	Quantity	Currently monthly or quarterly reports		
# of clients served that are part of underserved community	Quantity	Currently monthly or quarterly reports		

Part B: Use of Evidence

1. Numerous peer reviewed studies have been completed and published with evidence supporting that Coordinated Specialty Care is the standard of care for early episode psychosis care. The NIH, American Psychiatric Association, and others have established a base of literature supporting the implementation of coordinated specialty care to help people recover from psychotic episodes.
2. Are you planning to conduct a formal qualitative or quantitative program evaluation related to this proposal? Indicate what kind(s) of evaluation you will be conducting. Select all that apply.

__ No formal evaluation planned at this time
__ Not yet determined
_ Needs Assessment
_ Process or Implementation Evaluation

__ Summative Impact Evaluation (Randomized Control Trial (RCT) or Quasi-Experimental Design)

__ Summative Evaluation other than an Impact Evaluation

X Other (please describe or link): This proposal seeks to implement an established evidence-based practice with adherence to a fidelity model with regular reviews of provider fidelity.

Part C: Evidence-Based Practices

Evidence-based practice:	**Source:**
Coordinated Specialty Care for psychosis	Implementing coordinated specialty care for early psychosis: The RAISE Connection Program (Dixon et al., 2015) | CLEAR
NAVIGATE for First Episode Psychosis	https://www.navigateconsultants.org/publications.html

Statutory Change(s):

This change would require updates to Minn. Stat. 256B.0625 to clarify coverage and service payments.

Change Item Title: Federal Compliance: Medicaid Access Rule (AD-57)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	1,400	1,094	1,174
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	1,400	1,094	1,174
FTEs	**0**	**6**	**8**	**8**

Request:

The Governor recommends investments required to comply with the federal Medicaid Access Rule. The Medicaid Access Rule was published by the Centers for Medicaid and Medicare services (CMS) in May 2024 with the goal of improving access to care, quality and health outcomes, program integrity and better addressing health equity issues in the Medicaid program across fee-for-service (FFS), managed care delivery systems, and in Home and Community Based Services (HCBS) programs. These improvements will increase transparency and accountability, standardize data and monitoring, and create opportunities for states to promote active beneficiary engagement in their Medicaid programs, with the goal of improving access to care.

The Access Rule represents a wide-ranging project with a series of new requirements that state Medicaid agencies must complete, with deliverables due between 2026 and 2030. This proposal is focused on securing initial resources to begin work required to develop the reporting tools, systems, and oversight capabilities on the most immediate requirements due between 2026 and 2027.

Rationale/Background:

The Access Rule is focused on improving access to quality services for people in need of Medicaid supports, with a particular focus on HCBS. Many people who access these services experience service delays, high staff turnover, and poor-quality services. Others may not be able to access them at all based on where they live, their service needs, the languages they primarily speak, and other factors. The Access Rule seeks to improve:

- the level and impact of input from people accessing Medicaid services through participation in advisory groups.
- quality oversight of Medicaid programs through data reporting and trend analysis.
- service cost transparency through publication of all Medicaid rates, including variations based upon geographic region, population served, and provider type.
- consumer protections for people accessing Medicaid services through enhanced oversight of grievances and critical incidents.

By blending new quantitative metrics with qualitative feedback coming from advisory committees focused on the user experience for beneficiaries and the working conditions of direct support professionals (DSPs), the Access Rule project will provide the state with an opportunity to enhance our program performance evaluation and continuous quality assurance and improvement capabilities to ensure we are using state Medicaid dollars effectively on programs that truly improve the lives of people who need them.

Updated Advisory Groups
With the Access Rule, CMS requires that states improve their engagement with people who utilize Medicaid services, providers of Medicaid services, as well as direct support professionals who provide frontline support. This engagement must be done through the initiation and maintenance of multiple advisory committees known as the Beneficiary Advisory Committee (BAC), the Medicaid Advisory Committee (MAC), and an Interested Parties Advisory Committee (IPAG), each with its own required membership compositions. These groups are to provide the state Medicaid agency with feedback on policies and rates that impact their ability to receive or deliver quality Medicaid services.

While Minnesota currently has a variety of advisory groups, none currently match the member composition requirements detailed in the Access Rule, nor focus on the prescribed list of functions detailed by the Rule. The BAC and MAC together represent an update to the current Medicaid Services Advisory Committee (MSAC), with a renewed focus and revamped membership, while the IPAG would be new to the Minnesota Medicaid system.

Medicaid Access Rule references: 42 CFR §431.12, 42 CFR §447.203(b)(6)

Program Integrity and Quality Assurance
In addition to these work groups, the Access Rule requires new state reporting requirements to show how effective the state is in meeting individuals' service needs. States must report on waiver waitlist times (if applicable), access to homemakers, home health aides, and personal care and habilitation services, including the average time from eligibility determination to service provision, and the percentage of authorized service hours provided over the course of a year.

States must also report on the percentage of people who receive required person-centered planning and annual reassessments, and on a set of metrics known as the Quality Measures Set (QMS), which are chosen by CMS for the purpose of ensuring that states appropriately track and meet system performance targets. Minnesota is currently tracking several of these of these metrics, but many are not being tracked, and new IT systems capabilities need to be built to come into compliance with tracking and reporting requirements.

Medicaid Access Rule references: 42 CFR §441.311 , 42 CFR §441.474, 42 CFR §441.745

Medicaid Rate Transparency
States must now post all Medicaid rates on a public-facing website, along with any variation in rates based on population (pediatric and adult), provider type, or geographic location. Many of these rates are already published on the Department of Human Services website; the state simply needs to compile them into a single, easily navigable web page to the meet the requirements. However, there are two components of this requirement that will require funding.

One is building a data reporting tool that can capture highly complex rate modifiers used mostly in physical health payment rates that are applied to services when providers bill for them. This data is not currently formatted in ways that can show the level of detail required to demonstrate the variation of those rates by population, provider type, or geographic region.

The other is a data analytics tool that can compare Medicaid and Medicare rates for a subset of services, which must be completed for another new CMS-required rate report that must be published on the public-facing website.

Medicaid Access Rule reference: 42 CFR §447.203(b)

Grievance System Accountability
Another new requirement for states is to update their grievance policies to ensure grievances from people accessing FFS Medicaid services are reviewed with a similar depth required for managed care organizations

(MCOs). This requires significant state policy updates, as well as development of a state-based work unit that can accept, investigate, and resolve individuals' grievances related to the performance of service providers, lead agencies, and the state itself. This work unit will eventually require personnel and IT tools for case tracking and trending, but this request will specifically focus on securing funding for consultants and a lead staff to begin developing the capability.

Medicaid Access Rule references: 42 CFR §§441.301(c)(7), 441.464(d)(5), 441.555(e), and 441.745(a)(1)(iii)

Enhanced Protection from Abuse and Neglect
Finally, the Rule also requires additional functionality for critical incident management systems to better track abuse, neglect, and exploitation of people accessing Medicaid services. This will require a significant overhaul of current vulnerable adult and child maltreatment policies, incident reporting systems, and data tracking and trending systems.

A core component of the new requirements is that states must routinely analyze Medicaid billing claims for unreported critical incidents. This is a technical capability the state of Minnesota does not currently have. Creating this infrastructure will allow the state to not only identify unreported incidents, but also better track repeat occurrences of abuse, neglect, and exploitation, which, aligned with the quality metrics and grievance information collected through other elements listed above, will shine a light on service providers that fail to deliver the level of quality the state expects from its service providers.

This request focuses on hiring a contractor to assist in designing the data analytics and policies to meet the new requirements. For efficiency in design and use of planning resources, this contractor would also work on the grievance system requirements.

Medicaid Access Rule Reference: 42 CFR 441.302(a)(6)

Failure to Comply
If a state fails to comply with reporting requirements listed above, CMS "will not grant a waiver… and may terminate a waiver already granted." CMS may also withhold payments for failure to comply with Federal requirements.

Medicaid Access Rule references: 42 CFR §441.302 , 42 CFR §430.35

Proposal:

Updated Advisory Groups
DHS will create the required advisory groups by recruiting new members, training, and onboarding them to the Medicaid services operated by the state of Minnesota, with special attention on key issues that impact service recipients such as Medicaid policy changes, rates, service oversight, eligibility, and access to services.

The BAC and MAC will operate in close collaboration, as per federal guidelines, with the BAC holding routine meetings separate from the MAC to ensure beneficiary perspectives and concerns are not overshadowed by industry professionals. Members from the BAC will also serve on the MAC, as per federal guidelines. These groups will be supported by the same staff and resources.

These two groups combined replace the existing MSAC. MSAC members will be invited to join the new committees.

Special care will be focused on ensuring diverse members represent urban/rural/cultural communities as well as the wide variety in ages, healthcare needs, and service requirements experienced by people accessing Medicaid.

Staff time will be focused on coordinating and hosting meetings, acting as a liaison between the MAC/BAC and DHS, and managing relationships with the advisory members, which was noted as a top priority to combat members' burnout, turnover, and dissatisfaction.

Funds for the BAC and MAC will go towards:

- Member recruitment, member training and onboarding: $2,500 per year to ensure sufficient membership, accounting for member turnover and term limits. This includes costs of advertising and marketing these positions and the creation of electronic and printed onboarding and training materials.
- Member stipends: $9,900 annually to provide a $55 dollar stipend to each member for each meeting (20 members of the MAC, 10 members of the BAC). This will be an ongoing expense to pay advisory members for their time and commitment to improving Medicaid services.
- Consultant: An ongoing expense of $100,000 annually to ensure independent facilitation and moderation to promote trust, neutrality, and unbiased decision-making and analysis. The consultant will also assist with member recruitment and development of annual reports and recommendations.
- DHS support staff (2.0 FTEs): Staff will set up meetings, arrange for meeting space, ensure comprehensive meeting accessibility, recruit, onboard, train, and support advisory members, state agency staff, and consultant.

The Interested Parties Advisory Group (IPAG) will be an independent group with members recruited from the ranks of direct support professionals from statewide service providers. These groups will be held every two years and will supplement existing workforce shortage efforts being led by the Disability Services Division.

Funds for the IPAG will support:

- Member recruitment, member training and onboarding: $2,500 every other year to ensure sufficient membership, accounting for member turnover and term limits. This includes costs of advertising and marketing these positions and the creation of electronic/print onboarding/training materials.
- Advisory member stipends and gift cards: $12,000 every other year
- 1.0 FTE: DHS staff to set up meetings, arrange for meeting space, ensure comprehensive meeting accessibility, recruit, onboard, train, and support advisory members, state agency staff, and consultant.
- Consultant: $100,000 every other year for a contractor to moderate meetings and work with outside advisory members to draft their recommendations to DHS, ensuring neutrality, transparency, and unbiased decision-making and analysis. The consultant will also assist with the development of annual reports and recommendations
- Translator services: $1,080 every other year: $180 per meeting for 12 meetings
- Refreshments: $1,500 every other year

The feedback and recommendations developed by these committees must be used by the state Medicaid agency to inform policy decisions. These recommendations, combined with the enhanced data tracking capabilities required by the Access Rule, will greatly improve the agency's ability to respond to issues using quantitative measurements that can assess scope, scale, and impact of systemic issues; highlight gaps and areas of concern to target improvement; and assess the performance of targeted improvements in mitigating the issues discovered.

Program Integrity and Quality Assurance

The bulk of the work necessary to come into compliance with data reporting requirements is related to updating IT and data systems and enhancing staff ability to collect, monitor, and analyze required metrics. Technical upgrades will need to be made on the MnCHOICES platform, Medicaid Management Information System (MMIS), and the Transformed Medicaid Statistical Information System (T-MSIS).

Funding needed for Program Integrity and Quality Assurance includes:

- Updating MnCHOICES data elements to align with federal quality metrics requirements: $320,000 one-time technical update.
- Building a multiplatform data reporting capability to merge MnCHOICES and MMIS data elements to allow for accurate service access measurements: $120,160 one-time technical investment, with $24,032 ongoing costs.
- 2.0 FTEs in the Aging and Disability Services Administration (16L and 18L) to manage the new analysis and reporting workload.
- 2.0 FTEs (18L) in the Health Care Administration to lead T-MSIS system technical updates and manage ongoing data analysis and reporting workload.
- NOTE: An FFP of 75% is assumed for MNChoices updates. MMIS changes have a state share of 29%.

The first quality metrics reports are due to CMS in September 2026.

Medicaid Rate Transparency

The work required to come into compliance with rate reporting expectations will be focused on developing a reporting tool to pull physical health Medicaid rates from the MMIS system while listing and organizing all possible rate variations due to population served, provider type, geographic location, or other custom modifiers that may be included in a rate. There is currently no way to pull all the variations of these data points and stratify them in the manner that is now required by CMS. A customized reporting tool must be created to do this.

Funds will also be required to hire a data developer to create and manage data reports to compare Medicaid and Medicare rates for a subset of services, also stratified with the same population, provider, and location format. This will be complex, ongoing work that requires significant data translation between Medicare and Medicaid rates as the services paid for by the respective programs do not always share uniform definitions or formats.

Funds for Medicaid rate transparency will be used for:

- 1.0 FTE (MAPE 18L) ongoing to create and manage data reports comparing Medicaid to Medicare rates.

Grievance System Accountability

Updating Minnesota's Medicaid grievance response system is a relatively large project requiring updates to policy language and processes for collecting and responding to grievances, as well as development of a work unit capable of handling and resolving the grievances that will come in. The highest priority in this effort will be to create a system that makes filing grievances accessible for individuals accessing services and ensures their issues are resolved quickly.

This statewide, DHS-run grievance system would establish consistency in response to individual and systemic issues, creating greater equity and fairness for individuals accessing Medicaid services. Additionally, a state-run system can effectively triage issues that come in as a grievance that may be better handled through processes operated by licensing, provider enrollment, the Offices of the Ombudsman, law enforcement, or other entity based on the nature of the complaint. This uniform state system would also be well-positioned to identify and address issues related to program integrity, fraud, waste, and abuse, and facilitate seamless transfer to Department staff specialized to handle those issues.

Secondly, it will be important to create an efficient response system for state staff to be able to quickly address complaints and help resolve issues within the required 90-day resolution window.

Funding needed for the Grievance System Accountability include:

- $400,000 to hire a consultant for human-centered design to assist with developing an efficient, user-friendly system, handling stakeholder engagement, and completing project management duties.

- NOTE: Because of overlap between new grievance system requirements and those of critical incident management (see next item), these costs can be shared by hiring a single consulting team and potentially leveraging enhanced federal matching funds.

Enhanced Protection from Abuse and Neglect

This component represents a complete overhaul of Minnesota's Critical Incident Management system, including redefining what is considered a critical incident, re-writing and aligning current critical incident and maltreatment regulations found in 10 different locations within state statutes, and aligning the practices of multiple government entities including the Department of Human Services, the Department of Health, the Department of Children, Youth & Families, and Direct Care and Treatment, impacting tens of thousands of vulnerable adults and children as well as tens of thousands of service providers and stakeholders.

Because of the project's scope and complexity, DHS's intent is to hire a consultant to engage stakeholders, analyze policies, review vendors, and assess IT systems to develop a blueprint for improving Critical Incident Management—covering staffing, structure, workflows, roles, and other elements needed to track, respond to, and report incidents in compliance with the Medicaid Access Rule.

Updates to the critical incident management system are required to be completed by July 2029, but securing funds now is critical to begin designing the required system and policy updates. With the assistance of an outside of contractor, we will submit a draft design of how the system should operate, including IT support, data management, policy, and personnel.

Funds for Enhanced Protection from Abuse and Neglect will be used for:

- $400,000 (shared with above) for a consultant to help investigate design options, conduct stakeholder engagement, and recommend operational design changes and policy updates. As detailed in the previous section, the consultant will also support grievance system updates.

Fiscal Impact

Dollars in Thousands

Net Impact by Fund (dollars in thousands)			FY 26	FY 27	FY 26-27	FY 28	FY 29	FY 28-29
General Fund			0	1,400	1,400	1,094	1,174	2,268
HCAF								
Federal TANF								
Other Fund								
Total All Funds			0	1,400	1,400	1,094	1,174	2,268
Fund	**BACT#**	**Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	14	Access Rule Reporting SPIRE Admin (0,1.5,2,2)	0	315	315	372	372	744
GF	REV1	Admin FFP @ 32%	0	(101)	(101)	(119)	(119)	(238)
GF	14	Critical Incident/Grievance ADSA Admin	0	400	400	0	0	0
GF	REV1	Admin FFP @ 32%	0	(128)	(128)	0	0	0
GF	14	IP Advisory Staffing Admin (0,.75,1,1)	0	147	147	172	172	344
GF	REV1	Admin FFP @ 32% - IP admin Staff	0	(47)	(47)	(55)	(55)	(110)

GF	14	IP Advisory Contractor and Meeting Costs Admin	0	117	117	0	117	117
GF	REV1	Admin FFP @ 32% - IP Contract/Meeting	0	(37)	(37)	0	(37)	(37)
GF	14	MAC/BAC Staffing Admin (0,1.5,2,2)	0	304	304	358	358	716
GF	REV1	Admin FFP @ 32% - BAC/MAC Staff	0	(97)	(97)	(114)	(114)	(228)
GF	14	MAC/BAC Contractor and Meeting Costs Admin	0	123	123	123	123	246
GF	REV1	Admin FFP @ 32% - MAC/BC Contract/meeting	0	(39)	(39)	(39)	(39)	(78)
GF	13	HCA Rate Transparency/QA MAPE 18L (0, 2.25, 3, 3)	0	482	482	572	572	1,144
GF	REV1	Admin FFP @32%	0	(154)	(154)	(183)	(183)	(366)
GF	11	MnCHOICES System	0	80	80	0	0	0
GF	11	MMIS Systems	0	35	35	7	7	14
Fund	**BACT#**	**FTEs Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	13	HCA FTEs (0,2.25,3,3)	0.00	2.25		3.00	3.00	
GF	14	ADSA FTEs (0,3.75,5,5)	0.00	3.75		5.00	5.00	

Impact on Children and Families:

This initiative is focused on improving the quality performance of Medicaid services. The components of the Access Rule will give the state a better set of tools to identify systems gaps and address performance issues at the individual, provider, and state levels. Furthermore, the new advisory groups and grievance system expectations will enhance individuals' and family members' ability to share their concerns and ensure their problems are heard and addressed. It will also provide the state with quality metrics that will ensure individuals accessing Medicaid receive the quality care the state expects from its Medicaid system.

The work proposed gives the state an opportunity to better align grievances, critical incident management, and quality performance metrics to identify and understand systemic failures and rate program and provider performance. The information and feedback coming into the state through the Access Rule efforts can be leveraged for population-level health management, condition management, network adequacy, cost control, quality assurance, and targeted interventions that can be designed, launched, tested, and evaluated to prove effectiveness and efficiency before scaling and implementation.

Furthermore, the integration of individual claims analysis will allow the Medicaid system to better respond to individual needs, identify abuse and neglect, and ensure individuals and families receive supports that lead to positive outcomes in their lives.

This budget is designed with measurable, data-driven targets tied to the CMS Access Rule reporting and Minnesota's One Minnesota priorities so progress can be demonstrated and course-corrected:

• **Access and provider network improvements:** Using access monitoring metrics (individuals wait times, provider-to-enrollee ratios, provider quality), the proposal aims to reduce average wait times for pediatric mental health applications for waiver services and increase the number of pediatric behavioral health providers that accept Medicaid in underserved counties within the next 5 years. These metrics are consistent with state reporting expectations under the Access Rule and Minnesota DHS guidance.

• **Health and developmental outcomes:** By expanding early supports, adequate interventions, and appropriate oversight of HCBS, the state expects measurable improvements in the amount of time from application to service

provision, avoidable emergency department use, and early intervention rates – all predictors of better long-term educational and economic outcomes. CMS and peer reviews indicate that improving early access and care continuity yields better population health and reduced downstream costs. The Access Rule's HCBS provisions support these measures by improving coverage, reporting, and payment pathways.

Equity and Inclusion:

The proposed investments are explicitly targeted to reduce access and outcome gaps experienced by People of Color, American Indian and Alaska Native people, people with disabilities, LGBTQ+ people, other protected classes, and veterans. The proposal pursues equity through three interlocking strategies: targeted resource allocation; network and payment levers and meaningful engagement and governance; coordinated Beneficiary Advisory Councils, Tribal consultation, and community-based partners (including Tribal health systems, LGBTQ+ community health centers, disability advocacy organizations, and veterans' service organizations) that support active participation in design, monitoring, and corrective action. Together, these approaches are designed to remove structural barriers (cost, lack of clinicians, cultural mismatch, transportation/technology gaps) that disproportionately affect the identified groups, and increase both supply and relevance of services in communities that need them most.

Much of this phase of the Access Rule work is directed at internal DHS capabilities related to collecting and reporting on various quality metrics, including: time it takes to have services delivered after being deemed eligible; performance rates related to updating assessment information, completing person centered plans, and other task necessary to develop person-centered service plans; and deliver services that are meaningful, impactful, and an efficient use of state resources. Stratifying this data, as directed by CMS, to analyze variations by region, provider type, and population served will give us a better ability to monitor quality along specific measures. By further stratifying this data by other individual demographic factors, we will have the tools to assess needs and establish baselines against which we can measure future program performance to ensure services are meeting the specific needs of diverse groups.

The following engagement steps will be intentionally iterative, using early input to shape future policy drafts. Subsequent drafts will be circulated for feedback, and the final design will reflect recurring themes raised by intended beneficiaries.

Beneficiary Advisory Councils: We will convene BAC meetings that include representation from a wide variety of critical communities, such as communities of Color, Tribal representatives, disability advocates, LGBTQ+ youth advocates, and veterans' service representatives, to co-create priorities and service design specifications. BAC members will be compensated for their time and will be provided with confidentiality protections.

Tribal Consultation: We will hold formal government-to-government consultations and incorporate Tribal requests into our scope and funding mechanisms (e.g., provide flexibility on how funds are braided and used locally).

Community Partner Focus Groups: We will work with community-based organizations to lead focus groups in multiple languages. These groups will address barriers like language access, transportation, and hours of service, and drive toward preferred solutions.

Surveys and Data Review: We will analyze claims and social-determinants datasets, alongside community feedback, to prioritize ZIP codes and service types for investment.

Public Comment Window: We will post draft program rules and collect written comments. These comments will shape language access requirements, reporting timelines, and simplified contracting pathways for small community-based organizations.

This information can be of use not only for ongoing quality improvement but also to inform performance-based contracts for provider to reward improvements in serving specific populations. The combined data collected will provide a much more detailed analysis of the overall user experience of Medicaid services through an individual's service timeline - from assessment, to eligibility, to service planning, and ultimately service delivery.

With regards to stakeholder engagement, the advisory groups are, by nature, instruments for stakeholder feedback. Project plans include detailed recruitment strategies to specifically target diverse stakeholders from various regions, cultural backgrounds, languages primarily spoken, services used, health/disability diagnoses, ages, time in the system, etc.

For those elements that will have an external impact, namely the grievance and critical incident management systems, stakeholder engagement will be done after funding is secured.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

This proposal is not expected to have a substantial direct effect on Minnesota Tribal governments. However, DHS implementation of the Medicaid Access Rule will include the following avenues for engagement with Minnesota's Tribal governments:

- The Beneficiary Advisory Council required by the Medicaid Access Rule will include representation from Minnesota Tribal Governments.
- DHS will hold formal government-to-government consultations and incorporate Tribal feedback into the department's ongoing policy decision-making regarding funding mechanism strategies and flexibilities.

Impacts to Counties:

At present, there are no identified additional costs required for counties within the proposed activities. Suggested changes to the grievance and critical incident systems may impact county operations, but those would be determined after the first phase of work as described in this proposal is completed.

For activities related to updating the grievance and critical incidents, it is the intention of the agency to make design changes that allow for more efficiency in these systems and reduce county burden. It has, however, been reported by other states that have engaged with this work, that there may be an increased burden to counties at certain points of the process. However, most have observed a decrease in those burdens after new systems have been place long enough to become routine.

The nature of the data collected from all aspects of the Access Rule are specifically designed to improve disparities between geographic locations, where services available may differ wildly from one region to another.

County and lead agency engagement will begin once funding is allotted to the development of the systemic changes proposed, and they will be invited to assist in the design of those systems to ensure smooth and efficient operation.

IT Costs

Category	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*	*FY 2030*	*FY 2031*
Payroll						

Category	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*	*FY 2030*	*FY 2031*
Professional/Technical Contracts		80				
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)		35	7	7	7	7
Total						
MNIT FTEs						
Agency FTEs						

Results:

The goal of this project is to strengthen compliance with the CMS Access Rule by expanding monitoring, transparency, and beneficiary engagement so that Medicaid resources are used appropriately and equitably for individuals and families. Within three to five years, success will be evident through measurable reductions in inappropriate billing and service duplication, improved provider accountability and network adequacy, and increased trust from beneficiaries demonstrated through higher utilization of preventive services. We will know this change item is successful when waste, fraud, and abuse are reduced while access and equity outcomes for Minnesotans improve when compared to baseline measures.

For the ***Enhanced Advisory Groups*** requirements, progress will be evidenced in recommendations to the Dept. of Human Services from the advisory groups by July 2026. Reports from the MAC/BAC committees will be submitted annually thereafter and every other year for the IPAG.

For ***Program Integrity and Quality Assurance***, evidence of progress will be captured using metrics for time to service (date of eligibility determination to first service delivery) and other quality metrics defined periodically by CMS. This currently includes data on the percentage of individuals accessing HCBS who have recently updated medical assessments, program plans, functional needs assessments, and person-centered plans to ensure they are receiving services that align with current needs and their plans are updated at least annually. The expectation set by CMS is that 90% of HCBS recipients have updated assessment and plans. Many of the metrics captured in this component of the Access Rule have not yet been measured in Minnesota, and an initial baseline will need to be determined to evaluate system improvement over time. This part of the Access Rule is mostly focused on building the capability to capture, analyze, and compare metrics year-over-year rather than to set specific performance guidelines for states.

For ***Medicaid Rate Transparency***, the expected outcome is to have all Medicaid rates published on a public-facing website so Medicaid beneficiaries can assess and compare providers and understand how much their Medicaid services cost. This will also help ensure states can better understand the business environment of Medicaid service providers. The two primary metrics for ongoing evaluation are utilization rates for HCBS services in the areas of personal care, home health aide, homemaker services, and habilitation services, and comparisons between Medicaid and Medicare rates for primary care, OB/GYN, outpatient mental health, and outpatient

substance use disorder services. There are currently no minimum standards for these measures, but once the capability is built, the metrics captured will be used as a baseline to assess future performance

For ***Grievance System Accountability***, the primary outcome will be a report on recommendations for establishing the new grievance system. These recommendations will be reviewed for cost effectiveness, alignment to the values and goals of the agency, and user-friendliness of the system for Medicaid beneficiaries filing and tracking complaints and complaint resolution.

For ***Enhanced Protection from Abuse and Neglect***, the primary outcome will be a report with recommendations for how to adjust Minnesota's current critical incident management system to comply with new CMS requirements. These recommendations will be reviewed for cost effectiveness, alignment to the values and goals of the agency, and efficiency of the overall design to maximize features already in place under the current system.

All identified deliverables are required by CMS. Failure to comply may result in payments being withheld, new waivers not being granted, and existing waivers being terminated.

Measure	**Measure type**	**Measure data source**	**Most recent data**	**Projected change**
Time between eligibility determination and when a service is delivered	Quality	MnCHOICES assessment and MMIS	Currently not able to pull this data	This data will allow better tracking of the amount of time it takes people to find appropriate services in their communities.
Average payment and utilization rates for HCBS services	Quantity	MMIS	Not currently available with the required stratifications	This will allow better tracking of regional variations in rates and ability for people to find and consistently use services they've been deemed eligible for.
Medicaid vs. Medicare comparative rate analysis	Quantity	MMIS and CMS Medicare Physicians Fee Schedule	Not currently available for required services	This will help DHS where current Medicaid rates lag too far behind Medicare rates to sufficiently support providers to match the public need.
HCBS Quality Measures	Quality	MnCHOICES, T-MSIS, NCI survey measures	Currently, DHS can only collect the NCI measures for	This will help determine how effective the state is in meeting

Measure	Measure type	Measure data source	Most recent data	Projected change
			the required services.	individuals' needs and adjusting plans and services in a timely fashion as needs change.

Part B: Use of Evidence

Each deliverable was assessed using a guide published by ADvancing States and the National Association of State Directors of Developmental Disabilities Services, two national trade associations that advise states on federal Medicaid policy, providing support and technical assistance as needed. These assessments showed the areas DHS does not have the current capability to meet new requirements. In many cases, DHS has some of the required data or data collection structure in place, but not enough to meet the new requirements. This proposal reflects the items where DHS needs resources to meet those new requirements.

The contents of this proposal were also informed by quantitative and qualitative evaluations conducted by the Department of Human Services and partner agencies. Quantitatively, recent Access Monitoring Review Plan analyses and Medicaid claims data were used to identify gaps in the system, provider shortages, wait times, and disparities in service utilization across the state. Qualitatively, the state convened various advisory councils, Tribal consultations, provider listening sessions, and community focus groups to capture individuals' lived experiences with access barriers, service quality, and administrative challenges. Findings from both approaches consistently highlighted gaps in behavioral health, early intervention supports, and service quality, as well as concerns about administrative complexity and provider accountability. These evaluations directly shaped the proposal's emphasis on measurable access metrics, stronger fraud/waste/abuse safeguards, and investments in culturally responsive, community-driven solutions.

13. Are you planning to conduct a formal qualitative or quantitative program evaluation related to this proposal? Indicate what kind(s) of evaluation you will be conducting. Select all that apply.

__ No formal evaluation planned at this time
__ Not yet determined
__ Needs Assessment
__ Process or Implementation Evaluation
__ Summative Impact Evaluation (Randomized Control Trial (RCT) or Quasi-Experimental Design)
_X_ Summative Evaluation other than an Impact Evaluation
__ Other (please describe or link):

Department of Human Services
FY 2026-27 Biennial Budget Change Item

Change Item Title: Federal Compliance: Household members background study FBI compliance (IG-53)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	49	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	49	0	0
FTEs	**0**	**0**	**0**	**0**

Request:

The Governor recommends $48,600 from the general fund for IT in order to remove the requirement or authority for FBI checks for household members connected to adult day services and adult foster care. This change is needed to comply with federal regulations.

Rationale/Background:

The 2025 legislature passed language removing the requirement and authority to conduct Federal Bureau of Investigation (FBI) checks for child foster care and adoption household members. DHS has identified the need to extend that prohibition to include household members for adult day services and adult foster care to maintain compliance with federal regulations. This change removes the requirement and authority to conduct FBI criminal history checks for household members connected to adult day services and adult foster care. Under the National Child Protection Act/Volunteer for Children Act (NCPA/VCA) (34 USC 40102), the FBI checks criminal history for covered individuals, defined as owners, operators, employees, or volunteers ((34 USC 40104(9)). Household members do not fit any of those categories.

Household members connected to adult day services and adult foster care are still subject to the following background checks: Minnesota Bureau of Criminal Apprehension (BCA) check (Minnesota criminal records), Predatory Offender Registry check, Minnesota maltreatment check (Department of Human Services, Minnesota Department of Health, Department of Children Youth and Families, and county records), MNCIS rap back (Minnesota criminal court records), and Minnesota Government Access (MN court records). The household members are still fingerprinted, but the fingerprint is only used for the BCA check and will not be sent on to the FBI for a national criminal history records check.

Proposal:

This proposal seeks to align DHS Background Study statute, chapter 245C, with federal regulations. DHS is aligning state background studies chapter to the FBI requirement which do not include FBI checks for household members. Compliance with FBI requirements maintains DHS's access to FBI criminal history records for other study types. There are additional one-time funds requested to initiate a change in the Net Study 2.0 system related to background studies.

This change will ensure that DHS continues to receive FBI criminal history records for background study types which require this data. This proposal requires changes to NETStudy 2.0 to ensure that household members are correctly identified and that they receive the appropriate type of background study. This change will enable the system to collect information when the study is initiated about whether the individual is a household member or

in a different role. The system will then be able to identify the correct type of study, ensuring that national criminal record information is not requested for a household member.

The second change to NETStudy 2.0 will update the system so that studies for household members are assigned the correct permission for connecting, transferring, or affiliating with a different provider. Updating those permissions requires significant coding and testing to safeguard the integrity of the system.

Household members will be required to have a Minnesota only, name and date of birth type of background study instead.

Fiscal Impact:

NetStudy 2.0 systems changes are needed to implement this change. These costs will be one-time changes estimated at $48,600. NetStudy 2.0 changes include moving position information to Initiate Study screen; new reason code and IDEMIA service code; reason code assigned is based on position information; changes to CTA matrix.

Dollars in Thousands

Net Impact by Fund			FY 25	FY 26	FY 27	FY 25-27	FY 28	FY 29	FY 28-29
General Fund					49	49	0	0	0
Other Fund 1									
		Total All Funds			49	49			
Fund	**BACT**	**Description**	**FY 25**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	11	Net Study 2.0 systems cost			49	49	0	0	0
Requested FTEs									
Fund	**BACT**	**Description**	**FY 25**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**

Impact on Children and Families:

This proposal protects the safety and wellbeing of children and vulnerable adults while contributing to the availability of an appropriately vetted workforce for providers serving these vulnerable populations.

Equity and Inclusion:

The change will ensure consistency of background study requirements and an appropriately vetted workforce for impacted programs.

DHS uses an Equity Policy and Toolkit to advance equity goals. Additionally, DHS will continue to practice a participatory approach to community engagement and partner with internal and external representatives to validate that equity and inclusion programming produce tangible equity-related results. DHS will evaluate policies and implementation regularly to continuously identify opportunities for improvement.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
There are no anticipated impacts to counties.

IT Costs:
The Net Study 2.0 (NS2) vendor estimates approximately 300 hours of work to make the changes necessary to the system to effectuate the statutory change.

Results:
Part A: Performance Measures

13. The overall goal is to maintain compliance with federal regulations regarding FBI background checks.
14. The request to make these changes stems directly from recent changes in this same vein to child foster care and adoption household members. DHS has identified a need to comply with federal regulations on background checks on household members related to adult day and adult foster services.
15. The changes will be effective when DHS continues to receive criminal history records because the department has remained complaint with federal regulations.

Measure	Measure type	Measure data source	Most recent data	Projected change
Remaining in compliance with the FBI and federal regulations.	*No action taken again DHS for failure to comply.*	*No adverse actions taken.*	*NA*	*Continuing to receive criminal background studies from FBI.*

Part B: Use of Evidence

14. Have you previously conducted a formal quantitative or qualitative program evaluation that informed the contents of this proposal? If so, please briefly describe the evaluation. No.
15. Are you planning to conduct a formal qualitative or quantitative program evaluation related to this proposal? Indicate what kind(s) of evaluation you will be conducting. Select all that apply.

__X__ No formal evaluation planned at this time
__ Not yet determined
__ Needs Assessment
__ Process or Implementation Evaluation
__ Summative Impact Evaluation (Randomized Control Trial (RCT) or Quasi-Experimental Design)
__ Summative Evaluation other than an Impact Evaluation
__ Other (please describe or link):

Statutory Change(s):
245C.02, subdivision 15a, and 245C.05, subdivision 5

Department of Human Services

FY 2026-27 Biennial Budget Change Item

Change Item Title: MnCHOICES Efficiencies (AD-52)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	**0**	**0**	**0**	**0**

Request:
The Governor recommends making MnCHOICES assessment policy and system changes that are intended to create efficiencies in workflows specifically impacting lead agencies.

Rationale/Background:
Lead agencies are currently operating under significant capacity constraints due to the volume of MnCHOICES assessments requested. This proposal is part of an ongoing effort to increase efficiencies, with additional changes adopted in 2023 and 2024 legislative sessions.

This proposal outlines three targeted strategies to reduce the number of required assessments, support more sustainable workloads, and ensure continued quality in service delivery. This proposal is intended to reduce lead agencies' burden by decreasing the number of referrals sent to lead agencies for face-to-face assessments, reducing unnecessary screenings during MnCHOICES assessments, and standardizing policy so that all assessments are valid for 365 days, even if a person experiences a waiver closure due to a facility stay.

Proposal:
First, this proposal amends MN § 144.0724, subdivision 11 paragraph (a), clause (7) to remove the requirement that certain nursing facility level of care (NF LOC) criteria can be established only via in-person MnCHOICES assessment completed by a lead agency (county, Tribal Nation, or managed care organization).

There are five categories to meet nursing facility level of care in Minnesota and the MnCHOICES assessment assesses for all five categories. Separately, the Pre-Admission Screening (PAS) is required for all individuals being admitted to a Medicaid Certified nursing facility. The PAS assesses for four categories and does not include the level of care (LOC) criteria of the person's planned living arrangement being living alone or homeless along with another risk factor. Currently, a small set of referrals for people entering nursing facilities are sent to the county to establish NF LOC through a MnCHOICES assessment. This change will mean that Pre-admission Screening (PAS) process can determine NF LOC for all people entering nursing facilities. Counties will continue to receive a referral for further screening and evaluation if the PAS indicates that the person has a history or diagnosis of a serious Mental Illness (MI) or Developmental Disability (DD), if LOC cannot be determined, or if the person is under the age of 21.

Second, this proposal amends MN § 256.975 subdivision 7b to no longer require that an individual currently being served under the Alternative Care program or under a home and community-based services (HCBS) waiver receive

an Omnibus Budget Reconciliation Act Screening (OBRA I) as part of the annual assessment process for HCBS services. OBRA I will only be required at the time of nursing home admission. This proposal would reduce the time it takes to complete a MnCHOICES assessment by removing the OBRA Level I form that is currently required at every assessment and reassessment. Lead agencies conduct over 10,000 MnCHOICES assessments per month. With this change, the number of OBRA Level I forms completed monthly would be around 866.

Finaly, this proposal amends Minnesota § 256B.0911, by repealing subdivision 21, which states that a person receiving HCBS waiver services may return to the community on the same waiver program without another MnCHOICES assessment if they temporarily entered an institution for 121 or fewer days. Subdivision 21 was enacted in 2022 to reduce barriers for people with short-term stays (up to 121 days) in certain institutional settings. Subsequently, in 2024, the legislature modified statute to state that MnCHOICES assessments are valid for 365 days (§ 256B.0911, Subd. 20). While this statute reduced barriers for a specific population of people, repealing this provision will enable DHS to implement a uniform policy where all assessments are valid for up to 365 days, regardless of the setting.

Fiscal Impact

This proposal has an indeterminable budget impact. At this time, the department lacks sufficient data to determine a fiscal impact to forecasted programs.

Dollars in Thousands

Net Impact by Fund			FY 25	FY 26	FY 27	FY 25-27	FY 28	FY 29	FY 28-29
General Fund			0	0	0	0	0	0	0
Other Fund 1									
Other Fund 2									
		Total All Funds	0	0	0	0	0	0	0
Fund	**BACT**	**Description**	**FY 25**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
Requested FTEs									
Fund	**BACT**	**Description**	**FY 25**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**

Impact on Children and Families:

The repeal of MN Statute 256B.0911 Subd. 21 would align with hospital decompression efforts by eliminating the requirement to receive an assessment prior to discharge for children who have had a MnCHOICES assessment within 365 days.

Equity and Inclusion:

In an effort to address the growing waiting lists for MnCHOICES assessments, which have waitlists that may disproportionately impacted people of color, Native Americans, individuals with disabilities, members of the LGBTQ community, other protected classes, and Veterans, this proposal has been developed to streamline the process to be more efficient and better positioned to deliver culturally sensitive assessment services.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
This proposal will impact lead agencies as it will reduce referrals to lead agencies for in-person assessments related to NF admission or redetermination of NF LOC by 70%. The remaining 30% are people under the age of 21 who require an in-person MnCHOICES assessment prior to NF admission.

It will also reduce the number of screenings required to be completed at each MnCHOICES assessment and reduce the OBRA I screenings being completed by 95%. The OBRA I screening will still be required prior to NF admission and lead agencies will complete it when they receive the PAS referral.

The repeal of MN Statute 256B.0911 Subd. 21 would impact lead agencies by increasing their capacity (fewer reassessments would allow lead agencies to focus on initial assessments and urgent situations). It would reduce administrative barriers, improve service timeliness and create more consistency in practice. It would also align with hospital decompression efforts by eliminating the requirement to receive an assessment prior to discharge for people who have had a MnCHOICES assessment within 365 days.

IT Costs

Category	***FY 2026***	***FY 2027***	***FY 2028***	***FY 2029***	***FY 2030***	***FY 2031***
Payroll						
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software						
Training						
Enterprise Services						
Staff costs (MNIT or agency)						
Total						
MNIT FTEs						
Agency FTEs						

Results:
Part A: Performance Measures

Measure	Measure type	Measure data source	Most recent data	Projected change
Number of MnCHOICES assessments that are completed within the 20-day timeline	Percentage of total initial assessments completed on time	MnCHOICES data base	August 2025 46% on time completion	Would expect an increase to this % along with other efficiencies up to 80%

Part B: Use of Evidence

1. Have you previously conducted a formal quantitative or qualitative program evaluation that informed the contents of this proposal? If so, please briefly describe the evaluation. No
2. Are you planning to conduct a formal qualitative or quantitative program evaluation related to this proposal? Indicate what kind(s) of evaluation you will be conducting. Select all that apply.

__ No formal evaluation planned at this time
__ Not yet determined
__ Needs Assessment
__ Process or Implementation Evaluation
__ Summative Impact Evaluation (Randomized Control Trial (RCT) or Quasi-Experimental Design)
__ Summative Evaluation other than an Impact Evaluation
x Other (please describe or link): Will continue to measure % of assessments completed on time. A dashboard is being created to increase transparency in performance.

Part C: Evidence-Based Practices

Evidence-based practice:	Source:
List the names of program or activity that are evidence-based and directly funded by this change item.	*Provide a link to the clearinghouse or journal article that establishes the evidence for this change item.*
Not applicable	

Department of Human Services
FY 2026-27 Biennial Budget Change Item

Change Item Title: Rural Emergency Hospital Payment Methodology Technical Change (HC-52)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	**0**	**0**	**0**	**0**

Request:

The Governor recommends establishing a Medical Assistance (MA) rate methodology for critical access hospitals (CAHs) that convert to rural emergency hospitals (REHs). This proposal is budget neutral.

Rationale/Background:

The Consolidated Appropriations Act (CAA) of 2021 established REHs as a new category of Medicare provider in response to an increase in rural hospital closures and an effort to increase access to care in rural areas across the country. REHs are limited in the services they can provide, including emergency department services, observation care, and certain outpatient medical and health services elected by the REH so long as those services do not exceed an annual per patient average length of stay of 24 hours. In November 2022, the Centers for Medicare and Medicaid Services (CMS) released a final rule establishing the initial policies and procedures for this hospital type.

Many of the policies for REHs align with those for CAHs. However, if a CAH chooses to elect the REH designation, they lose their CAH designation. Changes to state statute are needed to ensure that hospitals in Greater Minnesota pursuing a REH designation can continue to be reimbursed on a cost basis for the outpatient services they deliver to residents.

Proposal:

This proposal preserves the ability for CAHs that transition to the REH to still receive their cost-based rate for outpatient services. When a hospital elects to become a REH they lose their CAH designation and thus would lose their cost-based outpatient rates. To date, one hospital in Minnesota has made such a change. This proposal would allow the department to continue to use the current cost-based outpatient rate methodology paid to all CAHs, which is calculated at 100% of their base year cost. Maintaining this rate is important as many facilities eligible for this opportunity have limited Medicaid patients and ensuring an adequate rate is one way to help maintain access to care. The effective date for this proposal is assumed to be August 1, 2026.

Fiscal Impact

This requires a minor systems edit to reverse a change that was made in 2024 but has a negligible cost. As such, this proposal is budget neutral.

Dollars in Thousands

Net Impact by Fund	FY 25	FY 26	FY 27	FY 25-27	FY 28	FY 29	FY 28-29
General Fund							

Other Fund 1									
Other Fund 2									
Total All Funds									
Fund	**BACT**	**Description**	**FY 25**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
Requested FTEs									
Fund	**BACT**	**Description**	**FY 25**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**

Impact on Children and Families:
This proposal does not have a direct impact on children and families. However, ensuring that REHs have a reimbursement methodology is imperative for access to care for families living in rural areas.

Equity and Inclusion:
This proposal does not have a direct impact on equity and inclusion. However, one hospital in Greater Minnesota has elected the REH designation, Mahnomen Hospital. The purpose of the REH status is to keep outpatient hospital facilities open in rural and underserved areas. This proposal will allow DHS to continue to pay these facilities at the higher cost-based rates and preserve health care access for MCHP enrollees living in Greater Minnesota.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

This proposal does not have a substantial direct effect on tribes. However, providing authority for DHS to pay REHs appropriately will ensure that Tribal members who utilize REHs for care can continue to do so without disruption.

Impacts to Counties:
This proposal does not have a significant impact on counties.

IT Costs
Changes are required in the MMIS system to allow for hospitals that designate as a REH to be paid using the same mechanism as CAH. This change is negligible in cost.

Results:
This is a technical proposal that ensure DHS is able to continue to pay hospitals that transition to REHs appropriately.

Statutory Change(s):
Minnesota Statute 256B.75, Paragraph (b)

Department of Human Services
FY 2026-27 Biennial Budget Change Item

Change Item Title: Updates to Hospital Directed Payment Program (HC-53)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	**0**	**0**	**0**	**0**

Request:
The Governor recommends technical changes to the statewide hospital directed payment program that was established during the 2025 legislative session. These changes conform statute with legislative intent and current department policy on the implementation of the directed payment program. This proposal is budget neutral.

Rationale/Background:
A new provider tax on hospitals licensed and located in Minnesota was passed during the 2025 legislative session. The tax funds a new directed payment arrangement for participating hospitals that aims to increase payment rates for inpatient and outpatient services to the statewide average commercial rate. The Minnesota Department of Human Services (DHS) coordinated with the Minnesota Hospital Association (MHA) to submit a preprint to the Center for Medicare and Medicaid Services (CMS) to establish this program. Hennepin Healthcare, the large safety net hospital located in Hennepin County, was granted the option to choose between two state directed payment options when the legislation was passed in 2025. DHS was later notified that Hennepin Healthcare exercised its option to opt out of this new arrangement given uncertainty at the federal level surrounding provider taxes.

Federal law changes included in the 2025 Reconciliation bill (H.R. 1) created uncertainty in the allowable magnitude of the directed payment which has an impact on the disproportionate share hospital payment language enacted last session. Large state directed payments were expected to result in hospitals being ineligible to receive a disproportionate share hospital payment. This would have resulted in a large decrease in fee-for-service payment rates. To maintain fee-for-service payment levels, statute was amended to recharacterize the disproportionate share hospital payments to regular rate payments. Total fee-for-service hospital payments would be reduced by one percent with this change. Initial guidance release by CMS after the passage of H.R. 1, indicates that allowable total payments under the state directed payment arrangements will be drastically reduced. This allows many hospitals to continue to receive the disproportionate share hospital payment amounts. However, final regulations have not been issued, resulting in some uncertainty.

Proposal:
This proposal would make three updates to the statewide hospital directed payment program that was passed during the 2025 legislative session. First, this proposal offers the safety net hospital located in Hennepin County, Hennepin Healthcare, an additional opportunity to opt in to the statewide hospital directed payment program now that federal law around provider taxes has been clarified. Second, this proposal clarifies legislative intent and current department policy that hospitals that did not opt in to the arrangement are not subject to the assessment to fund the directed payment program. Third, the proposal grants the Commissioner flexibility in determining if any of the disproportionate share hospital payments made to hospital receiving state directed payments need to

be converted to regular rate payments in order to maintain fee-for-service payment levels. The effective date of this proposal is assumed to be upon final enactment

Fiscal Impact

This proposal is budget neutral.

Dollars in Thousands

Net Impact by Fund			FY 25	FY 26	FY 27	FY 25-27	FY 28	FY 29	FY 28-29
General Fund									
		Total All Funds							
Fund	**BACT**	**Description**	**FY 25**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
Requested FTEs									
Fund	**BACT**	**Description**	**FY 25**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**

Impact on Children and Families:

Providing an additional opportunity for Hennepin Healthcare to assess which directed payment option best supports the hospital's fiscal health will ensure it is able to continue to provide services to Medicaid enrollee's, including children and families, most effectively.

Equity and Inclusion:

This proposal does not have a direct impact on equity and inclusion. However, providing an additional opportunity for Hennepin Healthcare to assess which directed payment option best supports the hospital's fiscal health will ensure it is able to continue to provide services to all Medicaid enrollees effectively, including people of color, Native Americans, people with disabilities and other protected classes. This proposal will not impact the way the hospital delivers services to underserved populations. Additionally, this proposal protects hospitals' disproportionate share hospital payments in light of H.R. 1 changes, which are a meaningful revenue source for hospitals that serve individuals enrolled in Medicaid.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

This proposal does not have a direct impact on Minnesota Tribal governments.

Impacts to Counties:

This proposal does not broadly impact counties.

IT Costs
This proposal is recommending technical changes to align with legislative intent and current policy, and as such, there are no systems changes or costs required.

Results:
This is a technical proposal that aligns statute with current policy and practice and, therefore, does not have direct measures of success.

Statutory Change(s):
Minnesota Statutes 2024, Section 256B.1973, Subdivisions 4 and 21.

Department of Human Services
FY 2026-27 Biennial Budget Change Item

Change Item Title: Federal Compliance with Certified Public Expenditures for Targeted Case Management (HC-54)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	**0**	**0**	**0**	**0**

Request:
The Governor recommends bringing Minnesota's targeted case management (TCM) services, provided by Counties on a fee-for-service (FFS) basis, into compliance with Medicaid payment requirements. This requires establishing a new cost-based rate methodology and reconciliation process. This proposal is budget neutral.

Rationale/Background:
TCM services are designed for a distinct group of people who are eligible to receive services such as children with severe emotional disturbances or adults with serious and persistent mental illness. Case management has existed as a separate, reimbursable Medical Assistance (MA) service since 1986. Case management services provide a person with access to assessment, planning, referral, and ongoing monitoring to support individuals with complex needs through a person-centered approach. Today, this benefit helps approximately 44,000 people annually, to gain access to needed medical, social, and educational services.

In 2013, the Center for Medicare and Medicaid Services (CMS) formally notified the Minnesota Department of Human Services (DHS) that bundled payments may violate provisions of section 1902 of the Social Security Act. In 2018, CMS notified DHS that the payment methodology must be cost-based and reconciled using a CMS-approved cost report and settlement process. The current certified public expenditure (CPE) process is not reconciled in accordance with federal requirements. All of these concerns will be addressed through the development of an approved cost report and reconciliation/certification process.

Since 2016, DHS has been working collaboratively with county partners as part of the Case Management Redesign (CMR) initiative. In fall 2022 and winter 2023 the CMR Finance Team, comprised of county and DHS staff, reached consensus on key components of a framework for a new statewide cost-based rate methodology that will bring FFS TCM provided by counties into compliance with federal Medicaid payment requirements. This proposal seeks to codify the agreed upon approach.

Proposal:
This proposal modifies the existing rate methodology for fee-for-service (FFS) child welfare, adult and children mental health, and vulnerable adults and developmental disability TCM provided by counties. The financing mechanism will be a CPE process based on a 15-minute unit of service using the Social Services Information System (SSIS) as a basis for identifying TCM time.

The CPE funding process is a cost-based payment methodology where county expenditures are certified as the non-federal share of the service cost and used to draw down the federal share of the service cost. Counties will receive an interim rate for applicable TCM service claims. Simultaneously, counties will collect data that reflects the actual cost for providing the TCM services. These costs will then be provided to DHS via a CMS-approved cost report. Annually, the interim rate will be reconciled to the actual costs for each county, and a final settlement will occur. Each reconciliation period some county cost reports will be audited to identify any issues. DHS will complete the reconciliation including taking steps to implement the settle up amounts no later than 3 years following the finalization of the cost reports. Settlement to actual costs is a requirement when using the CPE process for the non-federal share.

Once the new rate methodology is implemented and DHS has collected sufficient cost information from counties, DHS will set the annual interim rate to be equal to the per unit costs reflected in the most recently reconciled cost report that has been submitted to DHS for that county. Each county's interim rate will be the same for all applicable TCM service types.

Addressing CMS concerns will also include standardizing definitions around what are allowable case management costs for MA-eligible individuals.

Because no state funding is implicated in the rate changes, no forecast costs are assumed. The effective date of this proposal is assumed to be January 1, 2027.

Fiscal Impact

This proposal is budget neutral.

Dollars in Thousands

Net Impact by Fund			FY 25	FY 26	FY 27	FY 25-27	FY 28	FY 29	FY 28-29
General Fund									
Other Fund 1									
Other Fund 2									
		Total All Funds							
Fund	**BACT**	**Description**	**FY 25**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
Requested FTEs									
Fund	**BACT**	**Description**	**FY 25**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**

Impact on Children and Families:

TCM services are critical for both children and adults. Ensuring the service is delivered consistent with federal requirements is important to maintain access to this important service.

Equity and Inclusion:

Case management services are a crucial part of DHS' efforts to reduce health disparities. Minnesota's racial disparities in terms of both economic stability and health outcomes have been well documented. A body of evidence on the "social drivers of health" (i.e. stable housing, stable and sufficient income, adequate nutrition, and reliable transportation) has emerged over the past decade that demonstrates the intersection between poverty and a person's health and wellness. Case management services help remove barriers to successful engagement in health care, education, and employment. Case management is a tool that allows a person and their family to develop a trusting relationship with a person who is able to help them identify what their needs are and the resources available to address those needs.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

This proposal does not have an impact on Minnesota Tribal governments.

Impacts to Counties:
DHS has collaborated with county partners throughout the development of the framework for the new statewide rate methodology and we will continue to work closely as part of the implementation process.

IT Costs
Changes will be required for Agile Apps, MMIS, and SSIS to account for TCM claiming changes and new cost reporting. The legislature appropriated funding in the 2024 session to make these changes in consultation with the Minnesota Association of County Social Service Administrators, and as such, no additional systems costs are needed.

Results:
This is a technical change and does not have any expected measurable results.

Statutory Change(s):
Minnesota Statutes 256B.0625, subdivision 20, paragraphs (c) (d); 256B.094, subdivision 6, paragraphs (a) (b); Minnesota Rule 9505.0322.

Department of Human Services
FY 2026-27 Biennial Budget Change Item

Change Item Title: Sunset Supplemental Payment for Hennepin County Mental Health Clinic (HC-55)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	**0**	**0**	**0**	**0**

Request:

The Governor recommends a conforming update to place an end date on the authority to make a supplemental payment for the Medicaid services provided by the Hennepin County's mental health clinic. This payment method is no longer used or needed since Hennepin County's mental health clinic transitioned to a Certified Community Behavioral Health Clinic (CCBHC). This proposal is budget neutral.

Rationale/Background:

The supplemental payment to Hennepin County's mental health clinic was designed to augment the fee for service (FFS) fee schedule rates up to the clinic's actual costs for providing mental health services to Medicaid patients. The non-federal share of the cost of the additional payment was funded by Hennepin County via a certified public expenditure (CPE) equivalent to the Medicaid losses incurred by the clinic.

The clinic transitioned from an FFS mental health clinic to a CCBHC, which are paid on a cost basis and do not incur Medicaid losses. The clinic's transition to a CCBHC eliminated the rationale and the computational basis for the supplemental payment given the clinic is now paid at a rate equivalent to their incurred costs for delivering mental health services.

Proposal:

This proposal sunsets the authority to make the supplemental payment to the Hennepin County mental health clinic. This proposal assumes a sunset date effective upon final enactment.

Fiscal Impact

There is no fiscal impact for this proposal. The state share of the supplemental payments was funded using Hennepin County expenditures. The supplemental payments did not include any state funds, and no supplemental payment is being made since the clinic transitioned to a CCBHC.

Dollars in Thousands

Net Impact by Fund	FY 25	FY 26	FY 27	FY 25-27	FY 28	FY 29	FY 28-29
General Fund							
Other Fund 1							
Other Fund 2							

		Total All Funds							
Fund	**BACT**	**Description**	**FY 25**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
Requested FTEs									
Fund	**BACT**	**Description**	**FY 25**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**

Impact on Children and Families:

The elimination of the authority to make supplemental payments to the clinic will not impact the clinic's fiscal health or its ability to continue to provide services to families and children enrolled in Medicaid. The clinic's operations remain the unchanged and the Medicaid payments to the clinic are required to cover the clinic's costs since it transitioned to be a CCBHC.

Equity and Inclusion:

This proposal does not have a direct impact on equity and inclusion. This proposal eliminates the state authority for a payment that is no longer relevant or viable. The clinic's transition from an FFS clinic to a CCBHC was completed at the request of the clinic with the full understanding of the fiscal impacts of the change. The change will have no impact on the clinic's operations, viability, or populations served.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

This proposal does not have an impact on Minnesota Tribal governments.

Impacts to Counties:

This proposal does not have an impact to counties. This change is a conforming change needed as a result of the clinic's election to become a CCBHC. It will not impact payments to Hennepin County.

IT Costs

No IT changes are needed for this proposal.

Results

This is a technical change and does not have any expected measurable results.

Statutory Change(s):

Repeal Minnesota Statute 256B.198.

Department of Human Services
FY 2026-27 Biennial Budget Change Item

Change Item Title: Modifying the Definition of Residency for Non-Title IV-E Foster Children (HC-56)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	**0**	**0**	**0**	**0**

Request:
The Governor recommends allowing children in foster care who are placed in a Minnesota family foster home by another state but are not eligible for Title IV-E Foster Care, to be considered Minnesota residents for the purpose of Medical Assistance (MA) eligibility determinations. This is a budget neutral proposal.

Rationale/Background:
Children placed in foster care in Minnesota from other states, and who are not eligible for Title IV-E foster care services, are currently not considered Minnesota residents and are therefore not eligible for MA in Minnesota. Minnesota is among the few states that neither automatically extends MA coverage to children placed in non-Title IV-E foster care by another state, nor permits children in this situation to qualify through application without imposing a residency requirement. While these children are eligible for Medicaid through the placing state, out-of-state Medicaid enrollment poses substantial barriers to health care access.

Currently, the guardians of children who are placed in foster care in Minnesota - but are enrolled in another state's Medicaid program - must find Minnesota providers willing to complete burdensome paperwork processes to bill and accept that other state's Medicaid. Some providers refuse, and even if they accept, the process is lengthy and interferes with timely access to services. DHS has heard from foster families who give up altogether on the quest to find a willing provider who accepts the out-of-state Medicaid. This sometimes results in agencies needing to make other foster care placement arrangements for the child, which further disrupts a child's continuity of care. This proposal meets the Governor's objectives to reduce barriers to health care for all children.

Proposal:
This proposal would amend MA state residency statute to include children placed in foster care in a Minnesota family foster home by another state, who are not eligible for Title IV-E, as residents of this state. This change will clarify their status and facilitate determination of public program eligibility. To clarify their residency status, amendments are needed to the Interstate section of state plan and the state residency rules.

The proposal is budget neutral due to the very small number of non-Title IV-E Foster children placed in Minnesota by another state who do not already meet the Minnesota state residency Medicaid eligibility requirements. New enrollees in the MA program resulting from this change is estimated to be 100 or less per year. This proposal is assumed to be effective upon enactment.

Fiscal Impact

Dollars in Thousands

Net Impact by Fund			FY 25	FY 26	FY 27	FY 25-27	FY 28	FY 29	FY 28-29
General Fund									
Other Fund 1									
Other Fund 2									
		Total All Funds							
Fund	**BACT**	**Description**	**FY 25**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
Requested FTEs									
Fund	**BACT**	**Description**	**FY 25**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**

Impact on Children and Families:

The current residency definition creates an unnecessary health care access barrier upon a small group of non-Title IV-E Foster children placed in Minnesota by another state. For the children affected, this results in significant health care impacts and adversely influences the stability of their foster care placement. According to the Interstate Compact on the Placement of Children (ICPC) and Interstate Compact on Adoption and Medical Assistance (ICAMA) Deputy Compact Administrator from the Minnesota Department of Children, Youth, and Families (DCYF), children in this small population "are not getting any services (going months or year(s) without dental/annual checkups/therapy). It is common that we will see placements completely disrupt for children when the services they may have had in the other state (prior to moving to Minnesota) are stopped once they move to Minnesota." This disruption in care is often not anticipated, as Minnesota is unique in not permitting access to MA for this population. With the help of DCYF, DHS conducted outreach to other states to understand their policies and processes to inform this proposal and also consulted with the Association of Administrators of the Interstate Compact on the Placement of Children (AAICPC) National Office.

Equity and Inclusion:

The current definition of residency keeps in place an unfair health care access barrier for a group of non-Title IV-E Foster children placed in Minnesota by another state, which results in significant health care impacts and adversely influences the stability of their placement. This policy helps ensure all children placed in foster care in Minnesota have access to health care and mental health supports and contributes to the stability of foster care placements. Removing this barrier supports Minnesota families in adequately caring for these children during a crucial point in the child's life.

According to the Children's Bureau, "over 50 years of data demonstrate that Black, AI/AN [American Indian and Alaskan Native], and other children of color are disproportionately represented and have disparate outcomes throughout the child welfare process, including investigations, entry into out-of-home care, and exits from care." In addition, LGBTQIA2S+ make up 11% of the general population, and 30% of the foster care population .[1] Overall, children in foster care have much greater medical needs than children who are not in placement. "For

example, 20.6% of foster children will experience blindness and other vision defects compared to 11.7% of non-placed children; 14.2% of foster children will experience mood disorders compared to 2.3% of non-placed children; 8.9% of foster children will suffer from a developmental disorder while only 3.9% of non-placed children do."[2] Appropriately, the American Academy of Pediatrics (AAP) has classified children in foster care as "a population of children with special health care needs. Health is defined broadly in this population and includes medical, mental health, developmental, educational, oral, and psychosocial well-being."[3]

[1] "Addressing Disproportionality, Disparity, and Equity throughout Child Welfare." n.d. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://www.acf.hhs.gov/cb/focus-areas/equity.
[2] Clare O'Donnell, Accessing Health Care as a Foster Child, 24 J. Health Care L. & Pol'y 161 (2021). https://digitalcommons.law.umaryland.edu/jhclp/vol24/iss2/2
[3] Moira A. Szilagyi et al., Health Care Issues for Children and Adolescents in Foster Care and Kinship Care, 136 PEDIATRICS (2015), https://pediatrics.aappublications.org/content/136/4/e1131.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

This proposal does not have an impact on Minnesota Tribal governments.

Impacts to Counties:
MA eligibility and enrollment would not impact counties financially, but could alleviate administrative work that county workers experience helping families try to obtain coverage for services with Minnesota providers.

IT Costs
This proposal does not require any systems costs or changes because this proposal would make a minor change to the definition of state residency for MA.

Results:
This proposal recommends a minor change to the definition of state residency for non-Title IV-E for children placed in a Minnesota family foster home by another state to allow them to enroll in MA if they otherwise meet MA program requirements. The number of enrollees who meet the criteria for this expanded access is estimated be less than 100 annually. There are no resulting associated IT costs or performance measures needed.

Statutory Change(s):
Minnesota Statute 256B.056, Subdivision 1

Department of Human Services
FY 2026-27 Biennial Budget Change Item

Change Item Title: State Medical Review Team Waiver for Medical Records Fees (HC-57)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	**0**	**0**	**0**	**0**

Request:

The Governor recommends a technical change that specifically includes the Minnesota Department of Human Services' (DHS) State Medical Review Team (SMRT) in a statute that limits provider fees for medical records. This proposal is budget neutral.

Rationale/Background:

DHS SMRT currently has a small administrative budget (less than $10,000) to spend annually on medical record requests when providers charge per-page fees. SMRT spends administrative time fulfilling invoice processing and negotiating payments, payment coordination, and following up on billing disputes. This proposal aligns SMRT medical records billing practices with the Social Security Administration's (SSA) Disability appeals process.

Proposal:

Minnesota Statute § 144.292, Subd. 6(d) limits provider fees for medical records used in the SSA Disability appeals, allowing only a $10 retrieval fee and waiving fees entirely for individuals on public assistance or with civil legal or volunteer attorney representation. The statute does not explicitly include DHS SMRT, which conducts disability determinations for Medicaid eligibility when there is no SSA determination and level of care determinations for children seeking MA-TEFRA. This proposal would align the SMRT medical records billing practice with the SSA Disability appeals process and alleviate administrative workload and streamline efficiency in instances that SMRT is not able to directly access providers' electronic medical record systems. The effective date for this proposal assumed to be effective upon enactment.

Fiscal Impact

This proposal is budget neutral.

Dollars in Thousands

Net Impact by Fund	FY 25	FY 26	FY 27	FY 25-27	FY 28	FY 29	FY 28-29
General Fund							
Other Fund 1							
Other Fund 2							
Total All Funds							

Fund	BACT	Description	FY 25	FY 26	FY 27	FY 25-27	FY 28	FY 29	FY 28-29
Requested FTEs									
Fund	**BACT**	**Description**	**FY 25**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**

Impact on Children and Families:

This proposal allows SMRT staff to focus on the disability determination process, rather than spending time contacting providers to discuss medical record charges, requesting they be waived, and having to track that invoices are paid. The ability to spend more time following up on disability referrals received will ensure that Minnesotans requesting a disability determination through SMRT are able to move through the disability determination process more efficiently. Children with disabilities are among the most vulnerable individuals in our community; devoting time and resources to aid in their well-being is paramount to setting them up to receive health care supports for their mental health and physical needs, which aligns with this proposal.

Equity and Inclusion:

This proposal has a potential to indirectly reduce barriers for people with disabilities seeking health care requiring a disability determination by decreasing the amount of time SMRT staff spend on administrative work relating to invoices for medical records. Time currently used to follow up on invoices and request waiving or adjusting fees could be allocated to moving applicants and enrollees through the disability determination process more efficiently. There are no direct links to positive or negative equity outcomes associated with this project.

Tribal Consultation:

Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

This proposal does not have a direct impact on Minnesota Tribal governments.

Impacts to Counties:

This proposal does not have a direct impact on Minnesota counties. There is no financial impact to counties associated with this proposal, nor will it impact county operations.

IT Costs

This is a technical proposal that does not require any systems changes, but instead, will reduce administrative workload. As such, there are no systems costs or updates required.

Results:

Measure	***Measure type***	***Measure data source***	***Most recent data***	***Projected change***
Briefly write what is being measured.	*Select quantity, quality, or result. Please try to include 1 of each.*	*Describe how the data for this measure will be collected.*	*If currently collected, provide most recent data for this measure. If not currently collected, please write N/A.*	*If successful, describe the change expected on this measure and to what extent.*
FY 2023 SMRT funds spent on medical record retrieval costs	Quantity	Outgoing payments for medical records	$9,445.67	Decrease in costs associated in obtaining medical records
FY 2023 Invoices Paid for medical record retrieval costs	Quantity	Number of invoices paid for medical records	232	Decrease in number of invoices requiring payment
FY 2024 SMRT funds spent on medical record retrieval costs	Quantity	Outgoing payments for medical records	$4,442.50	Decrease in costs associated in obtaining medical records
FY 2024 Invoices Paid for medical record retrieval costs	Quantity	Number of invoices paid for medical records	103	Decrease in number of invoices requiring payment

The expected outcome of this statute change is a decrease in state dollars spent on medical records which are used to make a disability determination when the provider does not have electronic medical records. The decrease is expected to be noticeable upon enactment but will be best measured starting at the one-year mark. Complete elimination of the cost of records will not be achievable, as not all providers are Minnesota providers and would not be required to follow this statute; likewise, some providers will continue to charge to $10 retrieval fee for records requests allowable.

The money SMRT spent on medical records in FY 2023 is more than double the amount spent during FY 2024. This significant decrease is attributed the time SMRT staff spent contacting providers to request fees be waived or reduced.

The greatest impact this policy change would have is on the hours spent by SMRT staff fulfilling invoice processing, negotiating payments, coordinating payments, and following up on billing disputes. These hours are not currently tracked, therefore a quantitative measurement for this cannot be cited at this time, though the metrics of the staff currently dedicating time to these efforts are expected to increase with their availability to focus on the SMRT process versus the tracking of medical record invoices.

Part B: Use of Evidence

1. Have you previously conducted a formal quantitative or qualitative program evaluation that informed the contents of this proposal? If so, please briefly describe the evaluation.
2. Are you planning to conduct a formal qualitative or quantitative program evaluation related to this proposal? Indicate what kind(s) of evaluation you will be conducting. Select all that apply.

_X_ No formal evaluation planned at this time
__ Not yet determined
__ Needs Assessment
__ Process or Implementation Evaluation
__ Summative Impact Evaluation (Randomized Control Trial (RCT) or Quasi-Experimental Design)
__ Summative Evaluation other than an Impact Evaluation
__ Other (please describe or link):

Statutory Change(s):
Minnesota Statute § 144.292, Subd. 6(d).

Department of Human Services
FY 2026-27 Biennial Budget Change Item

Change Item Title: Budget Technical Changes (OP-46)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	(1,125)	(1,125)	(1,125)	(1,125)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	(1,125)	(1,125)	(1,125)	(1,125)
FTEs	**0**	**0**	**0**	**0**

Request:

The Governor recommends making technical changes to ensure that the Department of Human Services can implement policy changes as intended by the legislature.

This proposal includes the following technical changes:

- Aligning appropriated funds with the correct accounting structure
- Transferring authority for appropriated funds to other agencies implementing the funds
- Technical language corrections
- Clarifying grants issued Tribal governments as direct payments; and
- Specifying carryforward authority for some previously appropriated funds.

Rationale/Background:

The 2025 legislature passed a number of changes and appropriations in health and human services across multiple bills. This proposal fixes technical errors, ensuring that the Department of Human Services can implement policy changes as intended by the legislature.

Proposal:

Moving Grants to Different Budget Activity Codes (BACTs)

The Department of Human Services (DHS) evaluated current BACT structures and determined certain grant programs should be re-assigned to different BACTs to align better with agency mission and budget structure. This also corrects any erroneous BACT errors from the 2025 legislative session. Proposed changes are as follows:

- **Detecting, Preventing, Waste, Fraud, and Abuse BACT error**: In the 2025 legislative session, DHS received funding for a contractor to review claims before payment as well as a part-time contract case reviewer. The $26,000 appropriation for the part-time contract case reviewer was appropriated in BACT 11 but should be in BACT 18.

- **State Pharmacy Benefit Manager (PBM) BACT error.** In the 2025 legislative session, the funding for two contracts necessary to implement the state PBM were appropriated in BACT 33. These two contracts should be appropriated in BACT 13 as health care administrative expenses. One contract is a $3M (total funds) contract to establish the Minnesota Actual Acquisition Cost, which began FY2026 and is an ongoing expense. The second contract is $40M per year (total funds) to contract with a PBM beginning on January

1, 2027 (i.e., $20M in FY27, and $40M each FY thereafter). These two contracts were booked in a single line 2025 EOS Tracking Final.xlsx (row 339).

- **Transition Initiative Waivered Services BACT change.** In the 2025 legislative session, the technical change to move Homeless, Housing and Support Services Administration (HHSSA) grant accounts from BACT 57 to BACT 56 erroneously missed one program. The Transition Initiative Waivered Services program is appropriated $192K per year and should be moved from BACT 57 to BACT 56.

- **Children's Psychosis BACT change.** In the 2022 legislative session, the funding for a children's first episode of psychosis grant program was incorrectly placed in BACT 59 SUD grants. The program should be placed in BACT 58 as Children's Mental Health grants. The program is appropriated $361,000 per year.

- **Emergency Shelter Facility.** In the 2025 legislative session, the technical change to move HHSSA grant accounts to BACT 56 missed the Emergency Shelter Facility Grant. The grant was as a one-time appropriation beginning in SFY24 for $98,456,000 with end date of 6/30/2028. This technical change should move the remaining grant funds from BACT 47 to BACT 56. The Emergency Shelter Facility grant currently has $62,388,104.81 left to spend in SFY26 through 6/30/2028.

- **Emergency Services Program Grant.** In the 2025 legislative session, the technical change to move HHSSA grant accounts to BACT 56 missed the Emergency Services Program Grant. The grant was as a one-time appropriation beginning in SFY25 for $3,391,000 with end date of 6/30/2027. This technical change should move the remaining grant funds from BACT 47 to BACT 56.

- **Homeless Youth Cash Stipend Rider.** In the 2025 legislative session, the technical change to move HHSSA grant accounts to BACT 56 missed the Homeless Youth Cash Stipend. The grant was as a one-time appropriation beginning in SFY24 for $5,302,000 with end date of 6/30/2028. This technical change should move the remaining grant funds from BACT 47 to BACT 56. The Homeless Youth Cash Stipend currently has $2,782,316 left to spend in SFY26 through 6/30/2028.

Transfer of Authority and Appropriation Between Departments
This proposal makes the following changes across departments:

- **Regional Coordination and 24/7 Statewide Crisis Phone Services:** As part of the Adult Mental Health Grants base (BACT 57), DHS receives $1,125,000 per year to support regionally coordinated comprehensive suicide prevention services. DHS administers these funds via an interagency agreement (IAA) with the Minnesota Department of Health (MDH), which conducts the RFP for regionally coordinated services. This proposal appropriates these grant funds directly to MDH instead of to DHS.

Language Changes
This proposal includes the following statutory language error fixes:

- **SUD Modeled Rate Change:** This change is required to update 254B.05, subd 6 (b) to add Subd 5 reference before paragraph (a). This change fixes an error in the language and follows the intent and fiscal note for rate changes passed in the 2025 session.

- **Withdrawal Management Start-Up and Capacity-Building Scope Change:** This proposal changes language and is required to align Withdrawal Management Start-Up and Capacity Building Grants with current best practices. This technical change amends 254B.17 *Withdrawal Management Start-Up and Capacity-Building Grants* and makes language changes for ASAM criteria.

- **Rounding General Assistance Payments.** Effective October 1, 2024, General Assistance COLA increases went into effect. This proposal clarifies that GA payments should be rounded to the nearest dollar rather than to the cent. The change will take effect on October 1, 2026, and will simplify the calculation and administration of these payments, improve efficiency and reduce potential errors. The technical change amends Minnesota Statutes, section 256D.01, *Declaration of Policy; Citation*, to update the language to reflect rounding to the nearest dollar.

- **Resettlement Program Office (RPO) Legal Referral and Assistance Grants error.** In the 2024 Session, a number of programs were transferred to the jurisdiction of the then-to-be-created Department of Children, Youth, and Families (DCYF). The statute for the Legal Referral and Assistance Grants program, administered by the DHS Resettlement Programs Office (RPO) was transferred to DCYF in a technical article of Laws 2024, chapter 80. RPO was a part of the Children and Families Division of DHS when the original statute was passed in 2015, and the statute for this program was inadvertently included on a list of statutes that needed to change jurisdiction. The funding was not changed and is still in the DHS budget.

- **Adult Mental Health Initiative (AMHI) Funding:** In the 2025 legislation session, funding for Tribal and County AMHI programs transitioned from a grants-based model to a directed payment structure. This proposal clarifies the direct payment framework by defining direct payments, establishing expectations for documentation and reporting, and clarifying authority to issue, monitor, and audit direct payments. This change amends Minn. Stat. 245.4661.

Changes to Appropriation Mechanism
The agency seeks to change two payments methods to Tribes into direct appropriations.

- **Transition to Direct Payment of State Tribal Prevention Funds Change:** This proposal is to change the process of administering dollars to a direct payment to the Tribes for prevention work. This creates standards of ensuring equitable distribution of funds for underrepresented communities. This technical change amends 254A.03 *State Authority on Alcohol and Drug Use* to directed payments.

- **Direct Payment for Tribal Allocation Payments Change:** This proposal converts Tribal administrative allowance to a direct payment, rather than through a grants process. This recognizes Tribal sovereignty and aligns process with what is done for counties. This technical change amends Minnesota Statutes 2024, section 254B.02, subdivision 5 to directed payments.

Carryover Authority
This proposal changes the carryover authority for the following funding:

- **Gambling treatment provider rollover funding change.** This proposal amends 297E.02 Subd. 3 to allow funds to carry forward from year to year. These funds are from the Lottery Fund.

- **Pediatric Hospital-To-Home Pilot Extension:** This technical change extends the appropriation authorized the 2024 session (Ch. 125, Article 8, Sec. 2, Subd. 4c and Subd. 14c) from June 30, 2027, to June 30, 2028. This also extends the report due date from December 15, 2026, to December 15, 2027. This would impact BACT 14 (approximately $300k) and BACT 55 (approximately $1.04m).

Fiscal Impact

Minnesota Department of Human Services

Net Impact by Fund	FY 26	FY 27	FY 25-27	FY 28	FY 29	FY 28-29

General Fund			-	(1,125)	(1,125)	(1,125)	(1,125)	(2,250)
		Total All Funds	-	(1,125)	(1,125)	(1,125)	(1,125)	(2,250)
Fund	**BACT**	**Description**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	33	MA Admin. State PBM Contracts -Correction	-	(23,000)	(23,000)	(43,000)	(43,000)	(86,000)
GF	13	HCA Admin - State PBM Contracts -Correction	-	23,000	23,000	43,000	43,000	86,000
GF	11	OPS Admin - P/T Contract Case Reviewer	-	(26)	(26)	(26)	(26)	(52)
GF	18	OIG Admin - P/T Contract Case Reviewer	-	26	26	26	26	52
GF	57	Adult Mental Health Grants - Transition Init. Waivered Services	-	(192)	(192)	(192)	(192)	(384)
GF	56	Housing and Support Services Grant - Transition Init. Waivered Services	-	192	192	192	192	384
GF	59	Substance Use Disorder Grants - Children's Psychosis Grant	-	(361)	(361)	(361)	(361)	(722)
GF	58	Children's Mental Health Grants - Children's Psychosis Grant	-	361	361	361	361	722
GF	57	Adult Mental Health Grants - Regional Coordination and 24/7 Statewide Crisis Phone Services move to MDH	-	(1,125)	(1,125)	(1,125)	(1,125)	(2,250)
GF	47	Child and Economic Support Grants – Emergency Shelter Facility Grant	-	#	#	#	#	#
GF	56	Housing and Support Services Grant – Emergency Shelter Facility Grant	-	#	#	#	#	#
GF	47	Child and Economic Support Grants -Emergency Services Program Grant	-	#	#	#	#	#
GF	56	Housing and Support Services Grant - Emergency Services Program Grant	-	#	#	#	#	#
GF	14	ADSA Admin - Pediatric Hospital-To-Home Pilot Extension	-	#	#	#	#	#
GF	55	Disability Grants - Pediatric Hospital-To-Home Pilot Extension	-	#	#	#	#	#

Minnesota Department of Health

Net Impact by Fund			**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
General Fund			-	1,125	1,125	1,125	1,125	2,250
		Total All Funds						
Fund	**BACT**	**Description**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	1	MDH - Regional Coordination and 24/7 Statewide Crisis Phone Services	-	1,125	1,125	1,125	1,125	2,250

Impact on Children and Families:
This proposal makes technical changes that will improve the transparency and organization of the accounting structure. This proposal is not anticipated to have a substantive impact on children and families.

Equity and Inclusion:
This proposal makes technical changes that will improve the transparency and organization of the accounting structure, as well as technical changes that will facilitate implementation of previous legislative changes. This proposal is not anticipated to have a substantive impact on equity and inclusion.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☒Yes
☐No

This proposal makes technical changes to grant funding to Tribal governments that will improve processes.

Impacts to Counties:
This proposal is not anticipated to have a substantive impact on counties.

IT Costs:
This proposal does not have IT costs.

Results:

This proposal will improve the transparency and organization of the agency's accounting structure.

Part B: Use of Evidence

16. Have you previously conducted a formal quantitative or qualitative program evaluation that informed the contents of this proposal? If so, please briefly describe the evaluation. No.
17. Are you planning to conduct a formal qualitative or quantitative program evaluation related to this proposal? Indicate what kind(s) of evaluation you will be conducting. Select all that apply.

__X__ No formal evaluation planned at this time
__ Not yet determined
__ Needs Assessment
__ Process or Implementation Evaluation
__ Summative Impact Evaluation (Randomized Control Trial (RCT) or Quasi-Experimental Design)
__ Summative Evaluation other than an Impact Evaluation
__ Other (please describe or link):

Statutory Change(s):

Department of Human Services

FY 2026-27 Biennial Budget Change Item

Change Item Title: BH-70 Behavioral Health Fund County Share at 50%

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	(7,022)	(6,824)	(6,194)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	(7,022)	(6,824)	(6,194)
FTEs	**0**	**0**	**0**	**0**

Request:

The Governor recommends increasing the county share for the Behavioral Health Fund from 22.95% to 50%. This proposal saves $7.02 million in FY26-27 and $13.02 million in FY28-29.

Rationale/Background:

The Behavioral Health Fund (BHF) was established in 1986 to provide funding for substance use disorder treatment. It predates behavioral health parity requirements and was created at a time when Medicaid did not cover the current array of billable substance use disorder (SUD) services. The BHF was intended to serve as a statewide safety-net program for individuals who needed treatment but lacked coverage.

Today, people have substantially more options for accessing SUD treatment through both public and private insurance. Because the BHF's financial eligibility threshold closely align with Medical Assistance (MA) thresholds, most individuals who are eligible for the BHF will also be eligible for MA. As a result, the BHF is primarily used as a payor of SUD treatment when individuals are uninsured or underinsured. This could be due to waiting for an MA eligibility determination, gaps in coverage, services not covered by insurance, or ineligibility for MA due to incarceration or other disqualifying factors.

Currently, under Minn. Stat. 245B.03, counties are responsible for 22.95% of the cost of SUD treatment services when a resident of their county receives BHF-funded services, with the state funding the remaining share.

Proposal:

This proposal would increase the county share of BHF costs to 50% of the total cost of SUD services incurred by individuals in that county. This would exclude services to individuals who are residing in carceral facilities and receiving SUD services, which would continue to have a 22.95% county share. This proposal provides cost savings to the state of $7.02 million in FY27, $6.82 million in FY28, and $6.19 million in FY29.

Impact on Children and Families:

This proposal does not have a significant impact on children and families.

Equity and Inclusion:

This proposal is not anticipated to have a significant equity impact.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

This proposal does not have a substantial effect on Tribal governments, as they do not pay a county share.

Impacts to Counties:
This proposal will have financial impacts to counties as it increases the county share of BHF costs.

IT Costs
IT changes are not required for this proposal.

Results:
Results will be reflected in reduced state spending of $7.02 million in FY26-27 and $13.02 million in FY28-29.

Fiscal Detail:

Net Impact by Fund			FY 25	FY 26	FY 27	FY 25-27	FY 28	FY 29	FY 28-29
General Fund				0	(7,022)	(7,022)	(6,824)	(6,194)	(13,018)
Other Fund 1									
Other Fund 2									
		Total All Funds		0	(7,022)	(7,022)	(6,824)	(6,194)	(13,018)
Fund	**BACT**	**Description**	**FY 25**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	35	BHF County Share		0	(7,022)	(7,022)	(6,824)	(6,194)	(13,018)
Requested FTEs									
Fund	**BACT**	**Description**	**FY 25**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**

Statutory Change(s):
Minn. Stat. 254B.03
Minn. Stat. 254B.06

Department of Human Services

FY 2026-27 Biennial Budget Change Item

Change Item Title: Reduce Disability Grants (AD-72)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	(71,676)	(2,070)	(2,881)	(2,881)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	(71,676)	(2,070)	(2,881)	(2,881)
FTEs	**0**	**0**	**0**	**0**

Request:
The Governor recommends eliminating unnecessary and outdated grants focused on aging and disability services. These reductions focus on non-mandated grant programs, underspent or duplicative initiatives, and a large loan appropriation with sufficient existing balances and program integrity concerns, while preserving core, federally required, and direct-service programs.

Rationale/Background:
Minnesota faces a projected structural budget imbalance in the upcoming biennium, requiring the state to prioritize limited General Fund resources. The Department of Human Services (DHS) administers a number of grant and financing programs that are not federally required and that operate alongside larger entitlement and service delivery systems such as Medical Assistance and HCBS waivers.

Several of these programs:

- Have large unspent balances or limited demonstrated demand,
- Duplicate or overlap with existing service delivery or funding mechanisms,
- Were created as time-limited or policy-specific investments, or
- Present program integrity or fiscal risk concerns given current information.

In this fiscal environment, DHS must prioritize funding for:

- Federally required or court-ordered services,
- Direct service delivery to Minnesotans with disabilities, and
- Programs with clear accountability, outcomes, and demonstrated need.

Proposal:

This proposal repeals the following grant programs that are no longer needed to support the efficient operation of the aging and disability services system:

- **Disability Services Innovation Grants:** This program began in 2016 to support innovative ideas in the disability services system. Many ideas by this grant have now been incorporated into the disability waivers and no longer need the grant's support to be accessed. This proposal repeals this grant beginning Fiscal year 2027.

- **MnCHOICES Modifications Grant:** The MnCHOICES System is funded through other sources, making this grant redundant. This proposal repeals this grant beginning Fiscal year 2027.
- **Pre-Admission Screening Grant:** This grant reimburses counties for costs associated with federally-required pre-admission screenings to nursing homes. This grant does not fully cover county costs related to this work. This proposal repeals this grant beginning Fiscal year 2027.
- **Day Training and Habilitation Grants:** The 2025 Legislature repealed these grants to counties only for the fiscal years 2025-26 biennium. This proposal permanently eliminates this grant.
- **Long Term Services and Supports Loan Program:** This program was originally created in 2023 to support financially-distressed nursing homes. This program was expanded by subsequent legislatures to include several services with significant program integrity concerns. This proposal repeals this grant beginning Fiscal year 2027.

Impact on Children and Families:
These reductions do not affect eligibility for Medical Assistance, HCBS waiver services, or other core disability services. Most savings are achieved through the elimination of one-time or non-core grant and financing programs rather than direct service delivery. DHS will continue to prioritize services that support children, adults with disabilities, and families who rely on essential supports.

Equity and Inclusion:
While some discretionary and innovation-focused grants are reduced, the proposal preserves funding for programs that provide direct services and ensure access to supports across communities. DHS will monitor impacts and continue to prioritize equitable access to essential services.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
This proposal would eliminate the Pre-Admission Screen Grant that is provided to counties to support federally-required assessments. While the grant does not fully cover counties' full cost related to this work, this proposal would reduce county financial assistance received from the state.

IT Costs
No IT costs are associated with this proposal.

Results:
This proposal is expected to reduce state spending.

Fiscal Impact:

Net Impact by Fund (dollars in thousands)	FY 26	FY 27	FY 26-27	FY 28	FY 29	FY 28-29
General Fund	-71,676	-2,070	-73,746	-2,881	-2,881	-5,762
HCAF						
Federal TANF						
Other Fund						

Total All Funds			-71,676	-2,070	-73,746	-2,881	-2,881	-5,762
Fund	**BACT#**	**Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	52	Other Long Term Care Grants – Innovation Grants	-	(1,925)	(1,925)	(1,925)	(1,925)	(3,850)
GF	55	Disability Grants – MnCHOICES Modification	-	(125)	(125)	(125)	(125)	(250)
GF	55	Disability Grants – Pre Admission Screening Grant	-	(20)	(20)	(20)	(20)	(40)
GF	55	Disability Grants – DT&H Grants	-	-	-	(811)	(811)	(1,622)
DED	53	Aging and Adult Services Grants – LTSS Loan Program	70,854		70,854			
GF	NDR	Transfer In	(70,854)	-	(70,854)	-	-	-
GF	52	Other Long Term Care Grants – LTSS Loan Program (2024 Rider)	(822)	-	(822)	-	-	-

Department of Human Services

FY 2026-27 Biennial Budget Change Item

Change Item Title: Sustaining Disability Services Access through Efficiency Measures (AD-58)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	(2,268)	(25,917)	(66,141)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	(2,268)	(25,917)	(66,141)
FTEs	**0**	**0**	**0**	**0**

Request:

The Governor recommends growth reduction strategies to mitigate rising expenditures. Components of this proposal include:

- Limit billing for residential services to 351 days
- Changes to absence and utilization factor for day services
- Reversal of rate tier increases for Family Residential and Life Sharing Services
- Restrict residential overnight factor in Community Residential Services

Rationale/Background:

Minnesota has a long history of utilizing home and community-based services to support people with disabilities in the community, including people who had previously required services in an institutional setting. As a state, Minnesota focused on deinstitutionalization for people with disabilities decades before other states. We also eliminated the disability waiver waiting list while people living in other states continue to struggle with long waiting lists for home and community-based services. Minnesota has also used a variety of strategies through the Disability Waiver Rate System, including automatic inflationary adjustments and a competitive workforce factor, to provide the necessary resources to ensure that service providers are able to attract and retain quality direct care workers.

Recent state forecasts have shown that HCBS disability service costs have exceeded prior forecasts, driven by several factors including inflation, compounded rate increases, demographic changes, and higher-than-anticipated service utilization. To address these escalating costs, the Governor recommends slowing the cost growth through a variety of strategies. The governor is recommending this approach, as opposed to other blunt cost containment efforts used in the past, such as waiver growth limits or across the board immediate rate cuts, to mitigate impacts to people with disabilities.

Proposal:

Limit billing for residential services to 351 days

This recommendation places a cap on the number of billable days for HCBS Community Residential Services (CRS), restricting billings to a maximum of 351 days per year. This aligns with the current absence and utilization factor in 256B.4914 of 3.9%, which assumes 14 non-service days annually within the rates paid to providers. Providers

currently billing for more than 351 days effectively generate additional revenue without providing additional proportionate services.

The table below provides data on the total CRS expenditures in fiscal years 2020-2024, along with the number of people served and the percent of recipients for whom providers billed MA for 365 days of service.

FY	Total Paid	People served	Percent of people who had 365 days billed*
2020	$939,101,916	9,648	27%
2021	$1,151,627,392	12,455	32%
2022	$1,562,500,336	14,098	35%
2023	$1,735,987,273	13,897	38%
2024	$1,905,955,982	14,105	36%

*366 days in 2021 (a leap year)

This proposal component was previously recommended by the Blue Ribbon Commission on Health and Human Services. The 2019 Legislature authorized the Blue Ribbon Commission on Health and Human Services to develop an action plan "to advise and assist the legislature and governor in transforming the health and human services system to build greater efficiencies, savings, and better outcomes for Minnesotans." Specifically, the legislation charged the Commission to identify strategies in the final action plan that would enable the legislature to enact future legislation that would reduce health and human services expenditures by $100,000,000 for the biennium beginning July 1, 2021. The Commission met throughout 2019 and 2020 to solicit proposals from the community, analyze and organize strategies, and to gather feedback from community partners and stakeholders. Following this process, the Commission published a final report and submitted it to the Legislature, which included this recommendation.

Update absence and utilization factor in Day Services

This proposal reduces the absence and utilization factor for day services from 9.4% to 3.9%, bringing it in line with other service formulas in the disability waiver rate-setting methodology set in statute. This adjustment is based on actual utilization data and seeks to promote consistency across all services.

This proposal component was previously recommended by the Blue Ribbon Commission on Health and Human Services. The 2019 Legislature authorized the Blue Ribbon Commission on Health and Human Services to develop an action plan "to advise and assist the legislature and governor in transforming the health and human services system to build greater efficiencies, savings, and better outcomes for Minnesotans." Specifically, the legislation charged the Commission to identify strategies in the final action plan that would enable the legislature to enact future legislation that would reduce health and human services expenditures by $100,000,000 for the biennium beginning July 1, 2021. The Commission met throughout 2019 and 2020 to solicit proposals from the community, analyze and organize strategies, and to gather feedback from community partners and stakeholders. Following this process, the Commission published a final report and submitted it to the Legislature, which included this recommendation.

Family Residential Services (FRS) and Life Sharing Services Rate Tier

The 2025 Legislature enacted rate increases for Family Residential Services (FRS) and Life Sharing Services effective January 1, 2026 (Laws 2025, 1st Special Session, Chapter 9). While these increases were intended to strengthen provider capacity, they significantly add to the forecasted growth in waiver spending and are not data-based related to provider costs. To ensure sustainability of the disability service system, the Governor recommends reversing these statutory increases consistent with the law prior to the 2025 Legislative session.

Restrict Residential Overnight Factor in Community Residential Services

This proposal places a restriction on Community Residential Services to limit the selection of overnight staff value in the framework to asleep staff unless exceptions documentation is provided. An exceptions process will be developed to allow exceptions with documentation. This change is anticipated to go into effect January 1, 2027.

Interactive Effects
There are interactive effects between multiple components in the Governor's budget. If multiple strategies were to be enacted, the total fiscal impact to the state budget would need to account for the interaction between these strategies.

Impact on Children and Families:
Approximately 12.5% of individuals receiving HCBS waiver services in Fiscal Year 2023 were under the age of 18. This proposal could potentially impact children with disabilities who reside in a community residential setting.

Equity and Inclusion:
Minnesota's HCBS disability waivers serve over 70,000 people with a disability per year: Over 1,000 on the BI waiver, 800 on the CAC waiver, 24,000 on the DD waiver and over 43,000 on the CADI waiver. HCBS disability waivers serve a racially diverse population, with individuals identifying as Black, Indigenous, and People of Color (BIPOC) comprising a growing share of the waiver recipients, rising from 28.8% of the CAC, CADI & BI waiver population in 2019 to 33.9% in 2023.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
This proposal would not directly impact counties; however, counties administer Minnesota's Home and Community-Based Waiver services.

IT Costs
This proposal requires adjustments to the Medicaid Management Information System (MMIS) to limit community residential services billing to 351 days a year. Additionally, this proposal requires MnCHOICES Framework changes for Community Residential Services

Category	***FY 2026***	***FY 2027***	***FY 2028***	***FY 2029***
Payroll				
Professional/Technical Contracts	0	0	13	0
Infrastructure				
Hardware				
Software				
Training				
Enterprise Services				
Staff costs (MNIT or agency)	0	0	8	2
Total	0	0	21	2
MNIT FTEs				
Agency FTEs				

Results:

Type of Measure	*Name of Measure*	*Measure Data Source*	*Most Recent Data*	*Projected Change*
Fiscal impact	CRS Billing Days Reduction	CRS Expenditure and Billing data	FY 2023: 38% of recipients billed for 365 days	Reduction in billable days to 351 annually, aligning with absence/utilization factor, reducing unnecessary costs.
Policy Effectiveness	Customized Living Access Limitation for <55	CL Setting Compliance Data	2023: 90 individuals under 55 displaced due to age limitations	Reduced CL access for new recipients under 55 starting July 2026, ensuring service sustainability and compliance.
Access to Independent Living	Impact on Access to Own Home	HCBS Waiver enrollment and HCBS Settings data	High reliance on provider-controlled settings for some individuals	Enhanced focus on individual support plans to promote living in non-provider-controlled settings, fostering independence.

Fiscal Impact:

Net Impact by Proposal Component (dollars in thousands)

Component	FY 26	FY 27	FY 26-27	FY 28	FY 29	FY 28-29
Limit Billing to 351 Days	-	-	-	(3,182)	(32,232)	(35,414)
Absence & Utilization	-	(712)	(712)	(6,999)	(9,239)	(16,238)
Reverse FRS Tier Increase	-	(1,556)	(1,556)	(15,126)	(18,377)	(33,503)
CRS Overnight	-	-	-	(610)	(6,293)	(6,903)
Total	-	(2,268)	(2,268)	(25,917)	(66,141)	(92,058)

Fiscal Detail

Net Impact by Fund (dollars in thousands)			FY 26	FY 27	FY 26-27	FY 28	FY 29	FY 28-29
General Fund			-	(2,268)	(2,268)	(25,917)	(66,141)	(92,058)
HCAF								
Federal TANF								
Other Fund								
Total All Funds			-	(2,268)	(2,268)	(25,917)	(66,141)	(92,058)
Fund	**BACT#**	**Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	33	MA LW - Limit Billing 351	-	-	-	(3,190)	(32,234)	(35,424)

GF	11	MMIS - Limit Billing 351	-	-	-	8	2	10
GF	33	MA LW - Absence Utilization	-	(712)	(712)	(6,999)	(9,239)	(16,238)
GF	33	MA LW - Reverse FRS	-	(1,556)	(1,556)	(15,126)	(18,377)	(33,503)
GF	33	MA LW - Overnight CRS	-	-	-	(623)	(6,293)	(6,916)
GF	11	State share of MnCHOICES (75% FFP) - Overnight CRS	-	-	-	13	-	13

Change Item Title: Modify Nursing Facility Level of Care Eligibility for CADI/BI (AD-71)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	(2,612)	(16,634)	(26,015)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	(2,612)	(16,634)	(26,015)
FTEs	**0**	**0**	**0**	**0**

Request:
The Governor recommends modifying nursing facility level of care (NFLOC) criteria that determines eligibility for the Community Access for Disability Inclusion (CADI) and Brain Injury (BI) waivers in an effort to curb spending growth in the waiver programs.

Rationale/Background:
The legislature enacted changes to the nursing facility level of care criteria in 2009 as a part of a strategy to improve the sustainability of our publicly funded long term service and support system, and to ensure its availability for those with greatest need.

Federal maintenance of effort requirements delayed implementation of the modified NFLOC until January 1, 2014 for adults aged 21 and older. In 2020, DHS transitioned to one NFLOC for people younger than 21 years old and adults aged 21 and older.

To meet the criteria, a person must demonstrate at least one of the following:

- A high need for assistance in four or more activities of daily living (ADL); OR
- A high need for assistance in any one of 3 ADLs that requires 24-hour staff availability (critical ADLs of toileting, positioning or transferring); OR
- A need for daily clinical monitoring; OR
- Significant difficulty with cognition or behavior; OR
- The person lives alone and other risk factors are present.

According to the 2016 Nursing Facility Level of Care Initiative Final Report to Legislature, the number of individuals who lost eligibility because of the 2014 implementation of changes to NFLOC criteria was small.

Of 38,557 unduplicated in-person reassessments performed for individuals in the Elderly Waiver, CADI (age 21 and older) or Alternative Care programs between January 1 and December 31, 2015, 98.8% remained eligible for their HCBS program.

A decade later, the number of people that meet current nursing facility level of care for BI and CADI waiver programs continues to grow.

Proposal:

This proposal changes the criteria used to determine whether an individual meets NFLOC in the disability waiver programs by removing two eligibility criteria. This change would apply to all new program applicants, as well as people currently receiving CADI and BI services at their next annual reassessment.

In current law, NFLOC requires that a person must demonstrate at least one of the following:

- A high need for assistance in four or more activities of daily living (ADL); OR
- A high need for assistance in any one of 3 ADLs that requires 24-hour staff availability (critical ADLs of toileting, positioning or transferring); OR
- A need for daily clinical monitoring; OR
- Significant difficulty with cognition or behavior; OR
- The person lives alone and other risk factors are present.

This proposal removes:

- A need for daily clinical monitoring; and
- The person lives alone and other risk factors are present.

This change only impacts NFLOC determinations for CADI and BI and does not alter eligibility for Nursing Facilities, EW, or other Home Care services programs.

Individuals who no longer meet NFLOC will be provided with a notice of action informing them of their change in eligibility. Individuals who lose eligibility due this change will have waiver services terminated 90 days or more after the determining assessment, which is 60 days longer than current practice. Lead agencies must inform affected individuals of other benefits for which they may be eligible.

Impact on Children and Families:
This proposal could result in some children losing eligibility for the CADI or BI waiver programs.

Equity and Inclusion:
This proposal will impact people who receive services in our HCBS waiver programs. Demographics of those participants can be found here: LTSS demographic dashboard / Minnesota Department of Human Services.

According to the publicly available LTSS Demographic Dashboard, the population served by LTSS and HCBS in Minnesota is substantially more diverse than the general state population in several respects. As of the most recent LTSS report, among people receiving LTSS services statewide, approximately 39.5% identify as Black, Indigenous, or People of Color (BIPOC) — compared to a much higher proportion of white individuals in the general population. Because the population served by HCBS and LTSS is more racially and ethnically diverse than the general population — and includes many people with disabilities, younger adults, and people who rely on public supports — the changes proposed could have disproportionate impacts on BIPOC individuals, people with disabilities, and younger or working-age adults on waiver services.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
This proposal does not have a financial impact on counties.

IT Costs

This proposal requires adjustments to the Medicaid Management Information System (MMIS) to limit community residential services billing to 351 days a year. This would be a one-time cost of $25,000 for FY27.

Results:

This proposal is expected to reduce costs on the disability waiver programs.

Fiscal Impact:

Net Impact by Fund			FY 26	FY 27	FY 25-27	FY 28	FY 29	FY 28-29
General Fund			-	(2,612)	(2,612)	(16,634)	(26,015)	(42,649)
		Total All Funds	-	(2,612)	(2,612)	(16,634)	(26,015)	(42,649)
Fund	**BACT#**	**Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	33	MA LW FFS- Clinical Monitoring	-	(2,999)	(2,999)	(30,017)	(40,253)	(70,270)
GF	33	MA ED Managed Care- Clinical Monitoring	-	420	420	4,198	5,628	9,826
GF	11	MnCHOICES Systems Costs	-	25	25	-	-	-
GF	33	MA LF NF Payment System Changes	-	665	665	6,644	8,610	15,254
GF	33	MA LW FFS - 60 Day Delay	-	-	-	3,978	-	3,978
GF	33	MA ED Managed Care- 60 Day Delay	-	(280)	(280)	(556)	-	(556)
GF	33	MA LF Long Term Facilities- 60 Day Delay	-	(443)	(443)	(881)	-	(881)

Change Item Title: Limit Inflationary Adjustments in the Disability Waiver Rate System and Value-Based Reimbursement (AD-70)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	(923)	(3,543)	(23,076)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	(923)	(3,543)	(23,076)
FTEs	**0**	**0**	**0**	**0**

Request:

The Governor recommends limiting inflationary adjustments to two percent per year for disability waiver services in the disability waiver rate system and the value-based reimbursement system for nursing homes.

This proposal includes:

- Cap inflationary adjustments for the Disability Waiver Rate System (DWRS) at 4 percent per adjustment (2 percent per year)
- An identical inflationary cap for the Value-Based Reimbursement (VBR) system for nursing homes at 2 percent per year

This proposal also contains interactive impacts with other proposals in the Governor's budget package.

Rationale/Background:

Minnesota has a long history of utilizing home and community-based services to support people with disabilities in the community, including people who had previously required services in an institutional setting. As a state, Minnesota focused on deinstitutionalization for people with disabilities decades before other states. We also eliminated the disability waiver waiting list while people living in other states continue to struggle with long waiting lists for home and community-based services. Minnesota has also used a variety of strategies through the Disability Waiver Rate System, including automatic inflationary adjustments and a competitive workforce factor, to provide the necessary resources to ensure that service providers are able to attract and retain quality direct care workers.

Recent state forecasts have shown that the HCBS disability service costs have exceeded prior forecasts, driven by several factors including inflation, compounded rate increases, demographic changes, and higher-than-anticipated service utilization. To address these escalating costs, the Governor recommends slowing the cost growth through a variety of strategies. The governor is recommending this approach, as opposed to other blunt cost containment efforts used in the past, such as waiver growth limits or across the board immediate rate cuts, to mitigate impacts to people with disabilities. This proposal represents a portion of the strategies in this proposed approach.

Similar trends have been observed in the growth for nursing facility reimbursement rates since the implementation of VBR in 2017. Since 2017, rates have grown over 100 percent (averaging 6.13% annually per year), which is not sustainable for the State.

During the 2025 legislative session, the legislature implemented inflationary caps for both DWRS and VBR. The caps were 8 percent per adjustment for DWRS (for an effective rate of 4 percent per year) and 4 percent per year for VBR. This compromise emerged as a way of different portions of the long-term care services populations sharing the burden of cost saving measures.

Proposal:

Cap DWRS Inflationary Adjustments at 4 percent per adjustment (2 percent per year)
The Disability Waiver Rate System (DWRS) in Minnesota determines individualized payment rates for services provided under four disability waivers: Brain Injury (BI), Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC), and Developmental Disabilities (DD). DWRS ensures compliance with federal requirements and centralizes rate-setting, transferring responsibility from counties to the state.

During the 2025 legislative session, the legislature implemented a cap of 8 percent per adjustment, for an effective rate of 4 percent per year. This proposal further updates the limits by instituting a lower cap of 4 percent per adjustment, for an effective rate of 2 percent per year. This change would be effective January 1, 2027.

Cap All VBR Inflationary Adjustments at 2 percent per year
This proposal establishes a cap on the reimbursement to nursing facilities by limiting annual inflationary growth of the operating rates to two percent per year. The rate impact will be different per facility but will be an average decrease per resident day of, $1.47 for CY 2027, $3.94 for CY 2028, and $5.77 for CY 2029. This change will impact the Medicaid and private pay nursing facility rates effective on January 1, 2027, when the new limit to the total operating payment would be effective.

During the 2025 legislative session, the legislature implemented a cap of 4 percent per year. This proposal further updates the limits by instituting a lower cap of 2 percent per year effective January 1, 2027.

Interactive Effects
There are interactive effects between multiple components in the Governor's budget. If multiple strategies were to be enacted, the total fiscal impact to the state budget would need to account for the interaction between these strategies. *This proposal contains all interactive effects across all proposals in the Governor's budget.*

Impact on Children and Families:
Approximately 12.5% of individuals receiving HCBS waiver services in Fiscal Year 2023 were under the age of 18. This proposal could potentially impact children with disabilities who reside in a community residential setting.

The rate changes in this proposal could impact children and families if lower future rates impact the ability to attract and retain quality direct care workers, which may be exacerbated by growth in people needing care due to baby boomer demographic shifts as well as economic shifts in other industries making the job market more competitive.

Equity and Inclusion:
Minnesota's HCBS disability waivers serve over 70,000 people with a disability per year: Over 1,000 on the BI waiver, 800 on the CAC waiver, 24,000 on the DD waiver and over 43,000 on the CADI waiver. HCBS disability waivers serve a racially diverse population, with individuals identifying as Black, Indigenous, and People of Color

(BIPOC) comprising a growing share of the waiver recipients, rising from 28.8% of the CAC, CADI & BI waiver population in 2019 to 33.9% in 2023.

The inflationary cap in this proposal could impact people with disabilities if lower future rates impact the ability to attract and retain quality direct care workers, which may be exacerbated by growth in people needing care due to baby boomer demographic shifts as well as economic shifts in other industries making the job market more competitive.

The inflationary cap in this proposal would likely have impacts on direct care workers, as it would limit wage growth at a rate lower than inflation. Direct care workers in this field are disproportionately women and people of color. 7 percent of Minnesota's population identifies as black or African American. However, black workers constitute 22.7 percent of personal care aides and 20.5 percent of nursing, psychiatric and home health aides in Minnesota. While people of color make up 40 percent of the total U.S. labor force, they constitute 63 percent of all home care workers and 60 percent of residential care aides (PHI Direct Care Workers in the United States 2022). While immigrants make up 16 percent of the total labor force, they constitute 31 percent of the home care workforce, 22 percent of the residential care aide workforce and 22 percent of the nursing assistant workforce (PHI Direct Care Workers in the United States 2022). Women hold 76% of all health care jobs (Census.gov: Your Health Care Is in Women's Hands), 87.5% of home health aides, and 81.5% of personal care aides are women (U.S. Department of Labor: Employment and Earnings by Occupation).

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
This proposal will have a low to medium impact on counties in the form of savings, as counties have a share for Medicaid nursing home services. This proposal does not require county involvement in oversight, operations, or administration. Rates of disparities will not be impacted disproportionately in any county.

IT Costs:
There are no IT costs in this proposal.

Results:

Type of Measure	*Name of Measure*	*Measure Data Source*	*Most Recent Data*	*Projected Change*
Cost Control	Containing HCBS Spending Growth	DWRS and HCBS Fiscal Data	FY 2024 Spending on HCBS Services	Reduced disability waiver spending

Fiscal Detail:

Net Impact by Fund (dollars in thousands)	FY 26	FY 27	FY 26-27	FY 28	FY 29	FY 28-29
General Fund	-	(923)	(923)	(3,543)	(23,076)	(26,619)
HCAF						
Federal TANF						
Other Fund						
Total All Funds	-	(923)	(923)	(3,543)	(23,076)	(26,619)

Fund	BACT#	Description	FY 26	FY 27	FY 26-27	FY 28	FY 29	FY 28-29

GF	33	MA LW	-	-	-	(2,447)	(23,826)	(26,273)
GF	33 LF	MA NF Pymnt Sys changes	-	(1,369)	(1,369)	(4,434)	(8,028)	(12,462)
GF	33	Elderly Managed Care Rates	-	(87)	(87)	(291)	(547)	(838)
GF	33 LF	MA NF Interactivity	-	286	286	734	859	1,593
GF	33	Elderly Managed Care Interactivity	-	18	18	48	59	107
GF	33	MA LW - Interactivity	-	229	229	2,833	8,392	11,225
GF	33	MA FC - Interactivity	-	-	-	7	7	14
GF	33	MA ED - Interactivity	-	-	-	7	8	15

Department of Human Services
FY 2026-27 Biennial Budget Change Item

Change Item Title: Reinstating Parental Fees for Incomes Over 675% of Federal Poverty Guidelines (HC-66)

Fiscal Impact ($000s)	FY 2026	FY 2027	FY 2028	FY 2029
General Fund				
Expenditures	0	(1,122)	(12,894)	(16,910)
Revenues	0	(4,051)	(3,570)	(3,677)
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	(5,173)	(16,464)	(20,587)
FTEs	**0**	**2**	**2**	**2**

Request:

The Governor recommends reinstating parental fees for families with incomes of 675 percent of federal poverty guidelines or higher when Medical Assistance eligibility for their child with a disability is determined without regard to parental income. This proposal decreases General Fund expenditures by $5,192,000 in the FY2026-2027 biennium and $37,631,000 in the FY2028-2029 biennium.

Rationale/Background:

Medical Assistance (MA) under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) option and home and community-based waiver services (HCBS) provide services for children with a disability who are otherwise ineligible for MA because household income is above the standard MA income limit for children.

Prior to January 2024, a monthly parental fee was required and determined on a sliding scale according to household income. However, the child's MA eligibility under TEFRA or for HCBS waiver services was unaffected if the parent did not cooperate with parental fee requirements. In 2023, legislation was passed that eliminated all parental fees for parents whose child had MA under the TEFRA option or whose child received services under a HCBS waiver.

Proposal:

This proposal reinstates parental fees for families with incomes of 675 percent of federal poverty guidelines or higher and whose child has MA eligibility under the TEFRA option or receives HCBS waiver services. Federal poverty guidelines vary by household size. In 2026, 675 percent of the federal poverty guidelines is $142,763 for a family of two and $217,013 for a family of four.

Most recent DHS data indicates that these families account for 4.3 percent of all families receiving MA under the TEFRA option or receiving HCBS waiver services.

Fiscal Impact

This proposal re-establishes parental fees for TEFRA and for the purposes of accessing Home and Community Based Services (HCBS) to the levels prior to their repeal July 2023 for those with income 675% FPG or greater.

There are two ways in which this proposal decreases total expenditures to the General Fund. The first is through the increased monthly parental fee revenue. The second is through a decrease in MA and HCBS waiver caseload

and utilization due to the fee requirement. The estimated fiscal impact includes a 12-month phase-in. This proposal assumes an effective date of January 1, 2027.

With the elimination of parental fees, the TEFRA and child HCBS waiver population has grown significantly. As of September 2025, approximately 16,000 individuals were enrolled under the TEFRA option or HCBS waiver services, about 40% more than 3 years earlier, when parental fees were in effect. Absent any fee changes, it is assumed that this population would continue growing at 3% per year. Average MA payments for this population are around $5,000/month, and are assumed to grow at the same rate as overall disability waiver average payments.

Prior to the elimination of parental fees in July 2023, 3% of families in the TEFRA and HCBS waiver options fell into an income tier of 675% FPG or higher. We assume that due to the fee elimination, growth in the population over 675% FPG has been higher than in the general population, as the higher fees at higher income levels would have created more of a deterrent to enroll. The current estimate assumes that the percent of families with incomes over 675% FPG has doubled, to 6%. It is expected that there will be an MA program impact of re-instating the fees for this population, with approximately half of cases with incomes 675% FPG or higher disenrolling because of the reinstated fees.

FTE Costs
The Parental Fee Unit in the Financial Operations Division will require 2 MAPE 5L FTEs beginning September 1, 2026, to support the increased number of parental fee accounts that will be created due to a higher number of enrollees in TEFRA and child HCBS waiver MA options. This team is responsible for:

- Identifying TEFRA and waiver cases needing to submit tax information
- Sending notice to enrollees
- Assessing the income information to calculate any applicable fees
- Billing the fees in the state accounting system (SWIFT)
- Recalculating fees when families qualify for a variance (i.e. decrease in income, out-of-pocket medical expenses)
- Representing the agency at administrative hearings contesting the fees
- Performing annual renewals to accounts every year

In 2023, the parental fee unit had 4 FTEs to manage over 11,000 accounts that fell into this category. In FY2025 these programs have approximately 16,000 average monthly enrollees and an estimated 28,676 parental fee accounts, significantly increasing the caseload of the Parental Fee Unit staff.

Dollars in Thousands

Net Impact by Fund (dollars in thousands)			FY 26	FY 27	FY 26-27	FY 28	FY 29	FY 28-29
General Fund			-	(5,173)	(5,173)	(16,464)	(20,587)	(37,051)
HCAF								
Federal TANF								
Other Fund								
Total All Funds			-	(5,173)	(5,173)	(16,464)	(20,587)	(37,051)
Fund	**BACT#**	**Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	33ED	MA Grants	-	(1,350)	(1,350)	(13,094)	(17,110)	(30,204)
GF	REV2	Parental Fee Revenue	-	(4,051)	(4,051)	(3,570)	(3,677)	(7,247)

GF	11	State Share of Systems Costs	-	44	44	9	9	18
GF	11	FOD Admin (FTE 0, 2, 2, 2)	-	270	270	281	281	562
GF	REV1	Admin FFP @ 32%	-	(86)	(86)	(90)	(90)	(180)
Fund	**BACT#**	**FTEs Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	11	FOD Admin FTEs: MAPE 5L	0	2	2	2	2	2

Impact on Children and Families:
This proposal has the potential to limit access to Medicaid and HCBS waiver services for children with disabilities. These programs allow families the ability to access services most appropriate for their child's needs in a community setting. Some families of children with disabilities have employer sponsored health insurance. Employer sponsored health insurance typically does not cover all services needed for children with disabilities. Reinstating these fees may result in families foregoing necessary services for their children that would not be covered under other insurance types. Although a child's eligibility for MA under the TEFRA option or HCBS waivers is not impacted by nonpayment of parental fees, in the past parental fees have deterred some parents from applying for or enrolling their child in these programs.

Equity and Inclusion:
Reinstating parental fees will disproportionately impact families with children who have disabilities.

Tribal Consultation:
Does this proposal have a substantial direct effect on one or more of the Minnesota Tribal governments?

☐Yes
☒No

Impacts to Counties:
This proposal would increase administrative burden to counties as they would need to make referrals to the DHS parental fee review team. County eligibility workers would also be pressed to spend time educating and responding to families' questions regarding parental fees so families can determine if they want to proceed with the application and enrollment process.

IT Costs
This proposal would require changes in the Parental Fee System and cost of a total of $87,639 for initial development. These costs are total dollar estimates and do not reflect Federal Financial Participation (FFP).

Category	***FY 2026***	***FY 2027***	***FY 2028***	***FY 2029***	***FY 2030***	***FY 2031***
Payroll						
Professional/Technical Contracts						
Infrastructure						
Hardware						
Software						

Category	*FY 2026*	*FY 2027*	*FY 2028*	*FY 2029*	*FY 2030*	*FY 2031*
Training						
Enterprise Services						
Staff costs (MNIT or agency)						
Total		**$87,639**	**$17,527**	**$17,527**	**$17,527**	**$17,527**
MNIT FTEs						
Agency FTEs						

Results:

This proposal will reduce state costs.

Measure	**Measure type**	**Measure data source**	**Most recent data**	**Projected change**
Decrease programmatic expenditures to the General Fund	Quantity	DHS Forecast	Forecasted $30.2M for services in FY28-29	Eliminate forecasted costs for this service
Increase General Fund revenue through reinstating parental fees	Quantity	DHS Financial Operations Data	Estimated $7.25M in TEFRA parental fees in FY28-29	Increased $3.61M to General Fund in FY28-29

Other Proposals Impacting the Department of Human Services

Addressing Legacy Systems: Phased Roadmap to Modernized Eligibility (DCYF Proposal)

Proposal Summary:
The Governor recommends funding to address legacy IT systems used by county workers across social service programs with three investments. First, $25 million in FY 2027 and $5 million in FY 2028-29 to address MAXIS inefficiencies. The state will leverage federal matching dollars for these investments. Second, $2.650 million in FY 2027 for a comprehensive study to establish a phased roadmap to develop modernized program eligibility policies, processes, and technology with the ultimate goal of achieving a cross-agency modernized, universal eligibility determination capability. Third, funding to increase staff capacity at the Department of Children, Youth, and Families, the Department of Human Services, Minnesota IT Services, and the Children's Cabinet to provide coordination, strategic planning, and leadership for cross-agency systems modernization work.

Impact to the Department of Human Services:
Some populations in Minnesota's Medical Assistance program have eligibility determined in the MAXIS system. Updates to MAXIS will improve eligibility processes for these populations. Additionally, the Department of Human Services will work together with the Department of Children, Youth, and Families, Minnesota IT Services, and the Children's Cabinet to develop a roadmap for a universal eligibility system across human services programs. This proposal adds 4 ongoing FTEs at DHS to lead, develop, and implement technology modernization.

DHS Fiscal Impact:
Below are the DHS appropriations related to this proposal.

Net Impact by Fund (dollars in thousands)			FY 26	FY 27	FY 25-27	FY 28	FY 29	FY 28-29
General Fund			-	246	246	492	492	984
		Total All Funds	**-**	**246**	**246**	**492**	**492**	**984**
Fund	**BACT#**	**Description**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	11	OPS FTEs - Systems Modernization (0,2,4,4)	-	362	362	724	724	1,448
GF	REV1	FFP @ 32%	-	(116)	(116)	(232)	(232)	(464)
FTEs Description			**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	11	OPS FTEs - Systems Modernization	-	2		4	4	

State Office of Inspector General Established

Proposal Summary:
The Governor recommends establishing the State Office of Inspector General to investigate and prevent fraud and misuse of public funds across state programs. Responsibilities of this office would include: (1) conduct, review and oversee investigations, (2) consult on the selection of and establish standards for the work of agency Inspector Generals, and (3) lead improved data sharing between agencies for improved detection and alerting of potentially fraudulent actors in programs that cross agency boundaries. Included in this recommendation are staff and resources for existing agencies to facilitate data sharing and coordination with the Central OIG and make necessary fundamental systems improvements that better enable key programs to proactively identify and stop potentially fraudulent actors, an office staff of approximately 50 FTE that includes investigation and data research teams, and a case management system.

Impact to the Department of Human Services:
This proposal establishes a system for data sharing between the Central Office of the Inspector General and agencies so that the central OIG can lead improved detection of potentially fraudulent actors across the enterprise.

At DHS, expenditure and investigatory data are contained across multiple systems. This proposal requires systems investments that will combine and share investigative and expenditure data across the agency's multiple programs and systems. In addition to systems investments, staffing is required to coordinate data consolidation, transmission, and coordination with the central OIG. Staff will act as a liaison with the central OIG and will respond to the central OIG's requests for data, information, or administrative expertise regarding data, inspections, evaluations, and investigations of DHS-administered programs. Staff across the agency's administrations are also required to ensure that the central OIG can effectively receive, interpret and use investigative and expenditure data produced by DHS, and so that DHS can respond to questions and coordinate with the central OIG on both enterprise-wide and DHS data.

Additional DHS OIG investigators are needed due to an anticipated increase in referrals for investigations as a result from the work of the central OIG. DHS OIG legal staff are also required to facilitate MOUs and data sharing agreements with the central OIG, coordinate with the central OIG/DOJ/MFCU/BCA, advise on actions, and legal work required from the anticipated increase in referrals for investigations from the work of the central OIG.

DHS Fiscal Impact:
Below are the DHS appropriations related to this proposal.

Net Impact by Fund			**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
General Fund			-	2,055	2,055	2,425	2,425	5,456
		Total All Funds	**-**	**2,055**	**2,055**	**2,425**	**2,425**	**5,456**
Fund	**BACT**	**Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	11	DHS Central OIG Coordination (0, 1, 1, 1)	-	157	157	186	186	372
GF	18	OIG Investigations (0, 2, 3,3)	-	257	257	400	400	1,392
GF	18	OIG Legal (0, 1,2,2)	-	176	176	406	406	1,112
GF	18	OIG Data Analytics FTE (0,2,2,2)	-	252	252	385	385	770
GF	11	FOD Data and Central OIG Coordination (0,1,1,1)	-	126	126	186	186	372
GF	11	Compliance/Audits Data and Central OIG Coordination (0,1,1,1)	-	126	126	186	186	372
GF	13	HCA Data and Central OIG Coordination (0,1,1,1)	-	126	126	186	186	372
GF	14	ADSA Data and Central OIG Coordination (0,1,1,1)	-	126	126	186	186	372
GF	15	BHA Data and Central OIG Coordination (0,1,1,1)	-	126	126	186	186	372
GF	REV1	Admin FFP @ 32%		(471)	(471)	(738)	(738)	(1,762)
GF	11	NS2 Systems changes for background studies interfacing with the Hub	-	243	243	49	49	98
GF	11	NS2 Systems changes update privacy notices	-	5	5	1	1	2
GF	11	MNIT investigations and expenditure data systems costs (50% state share)	-	456	456	456	456	912
GF	11	Data Analytics Data Lakehouse systems software	-	350	350	350	350	700
FTEs Description								
Fund	**BACT**	**Description**	**FY 26**	**FY 27**	**FY 26-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	11	Operations FTEs	-	3		3	3	
GF	13	Health Care Administration FTEs	-	1		1	1	
GF	14	Aging & Disability Services FTEs	-	1		1	1	
GF	15	Behavioral Health Administration FTEs	-	1		1	1	
GF	18	OIG FTEs	-	5		7	7	

Technical Funding Adjustments (DCYF Proposal)

Proposal Summary:
The Governor recommends technical changes at the Department of Education and the Department of Human Services to fully align funding sources with legislative intent during the establishment of the Department of Children, Youth and Families (DCYF). Changes include: shifting funds from the Department of Human Services to the Minnesota food shelf program at the Department of Children, Youth, and Families; updating statute to clarify that administration of child protection grants from the opioid epidemic response fund is a responsibility of the Department of Children, Youth, and Families; separating preschool assessment funding from kindergarten assessment funding; and extending the availability of funding for the phase-in of the Minnesota African American Preservation and Child Welfare Disproportionality Act (MAAFPCWDA).

Impact to the Department of Human Services:
This proposal makes the following changes related to alignment of DHS and DCYF budgets:

- **Food Shelf Funds**: This proposal also includes a technical correction for the Food Shelf funds that have moved from DHS to the Department of Children Youth and Families (DCYF). This change moves $407,000 from DHS to DCYF. Currently, these funds are transferred to DCYF through an IAA.

- **Fraud Protection Investigation Grants:** This proposal also includes a technical correction for the Fraud Protection Investigation (FPI) grant funds that have moved from DHS to the Department of Children Youth and Families (DCYF). This change moves $425,000 from DHS to DCYF. Currently, these funds are transferred to DCYF through an IAA.

- **Opioid Epidemic Response Fund (OERF):** Under Minn. Stat. section 256.043, subdivision 3(m), DCYF is appropriated a portion of OERF funding for distribution to county and Tribal social service agencies. However, in subdivision 3(f), the funding for administering this funding remains appropriated to DHS. This section was missed during previous work to recodify statutes for implementation of DCYF. This proposal would shift this $321,000 annual appropriation from DHS to DCYF.

DHS Fiscal Impact:
Below are the DHS appropriations related to this proposal.

Net Impact by Fund			FY 26	FY 27	FY 25-27	FY 28	FY 29	FY 28-29
General Fund			-	(832)	(832)	(832)	(832)	(1,664)
Opioid Epidemic Response Account				(321)	(321)	(321)	(321)	(642)
		Total All Funds	**-**	**(1,153)**	**(1,153)**	**(1,153)**	**(1,153)**	**(2,306)**
Fund	**BACT**	**Description**	**FY 26**	**FY 27**	**FY 25-27**	**FY 28**	**FY 29**	**FY 28-29**
GF	56	Food Shelf Funds move to DCYF	-	(407)	(407)	(407)	(407)	(814)
GF	56	Fraud Prevention Investigation Grants move to DCYF	-	(425)	(425)	(425)	(425)	(850)
OERF	15	Opioid Account Administrative Funding move to DCYF	-	(321)	(321)	(321)	(321)	(642)