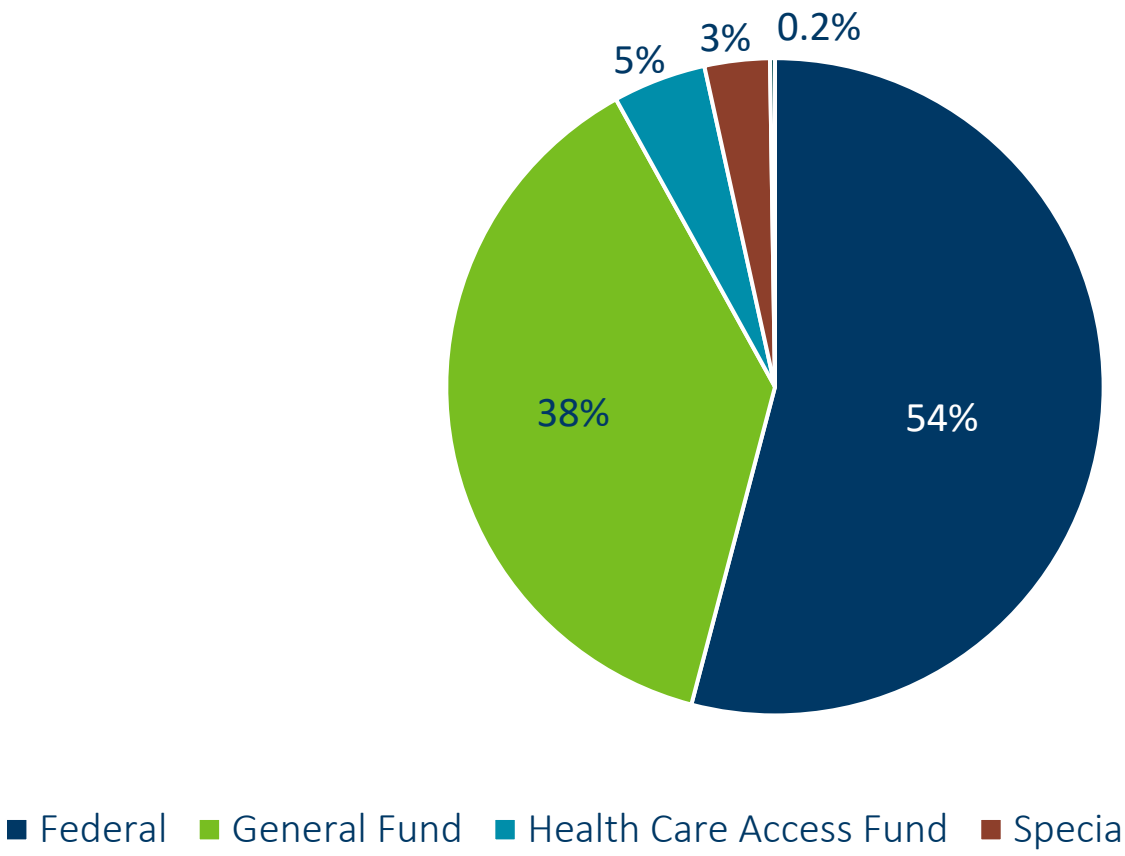
DEPARTMENT OF HUMAN SERVICES

2026 Supplemental Budget

House Health Finance & Policy Committee
April 8, 2026

Current DHS Budget – Source of Funds

FY2026 Projected Expenditures by Funding Source

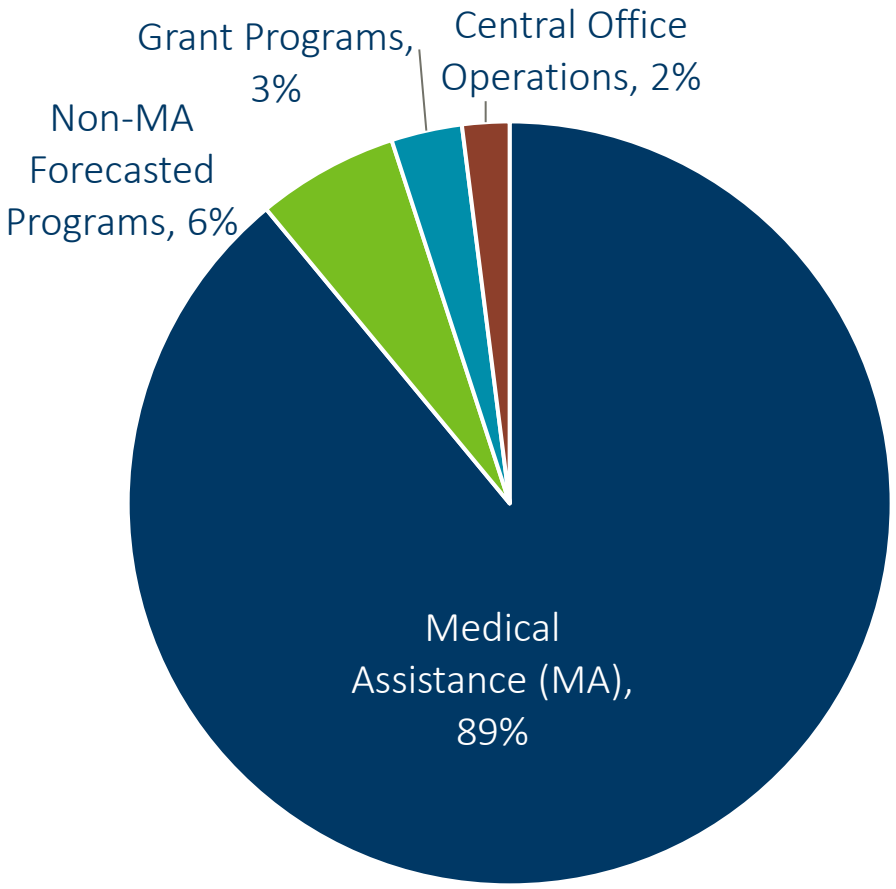


FY2026 Total Projected Spending:

- **Federal:** $15.2B
- **General Fund:** $10.6B
- **HCAF:** $1.3B
- **Special Revenue/SGSR:** $901M
- **Other:** $68M

Total: **$28.1B**

Current DHS Budget – How it is spent

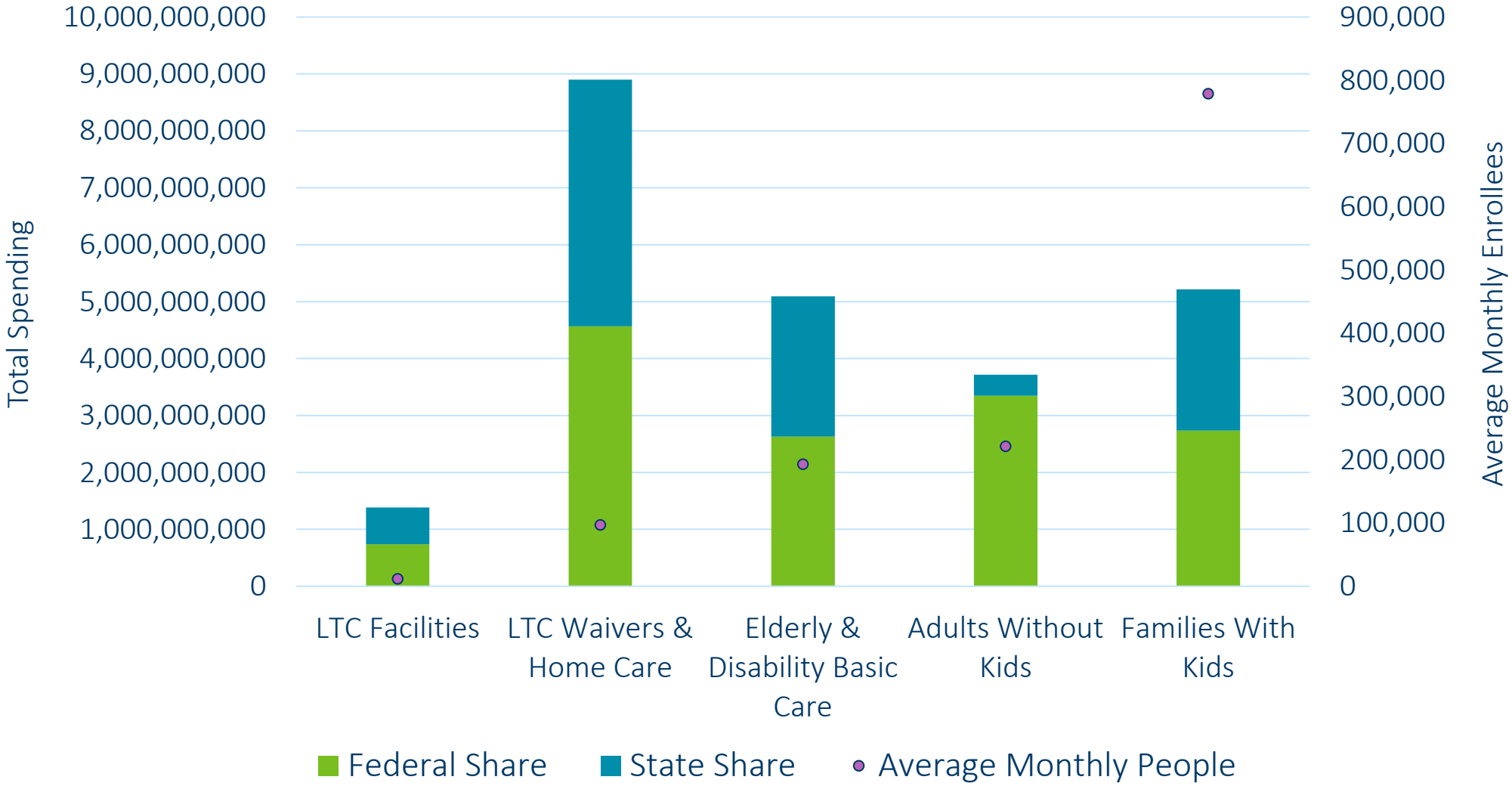


95% of the budget is spent on Forecasted programs, including:

- Medical Assistance
- MinnesotaCare
- Behavioral Health Fund
- Minnesota Supplemental Aid (MSA)
- General Assistance
- Housing Support

3% of the budget is spent on grants

2% of the budget is spent on operations (admin & systems)



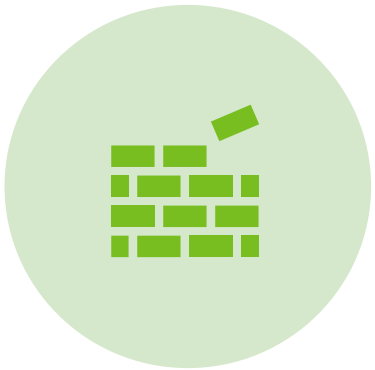
1.2 million average monthly enrollees

$24 billion total dollars

57% of spending funded by Federal Funds

Snapshot of Minnesota's Medicaid Program (FY26 – Feb. 26 Forecast)

2026 DHS Governor's Budget



Transform the Human Services System

Respond to Federal Action

Strengthen program integrity

Targeted Investments

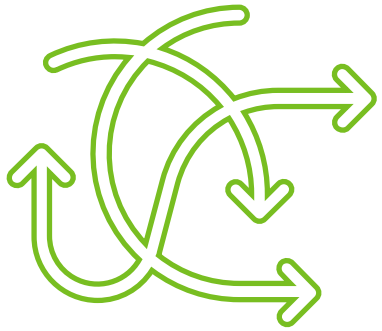
Curb spending growth

Summary of DHS Proposals (across jurisdictions)

Proposal Category	Proposals	FY26/27	FY28/29
Human Services Transformation	2	14,528	54,256
Federal Response	3	11,458	(34,794)
Program Integrity	10	(172,731)	(300,282)
Other Investments	4	1,959	13,921
Budget Neutral	10	(3,431)	(4,556)
Savings Proposals	6	(91,744)	(217,157)
Grand Total	35	(239,961)	(488,612)

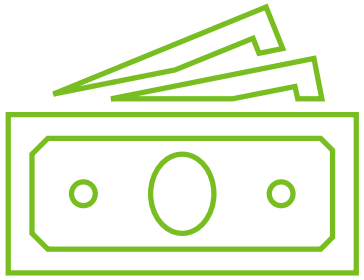
Transforming the Human Services System

Why transform the human services system?



Minnesota's human services system is challenging for people to navigate.

Program complexity has grown dramatically over time, making it difficult to administer within the current structure.

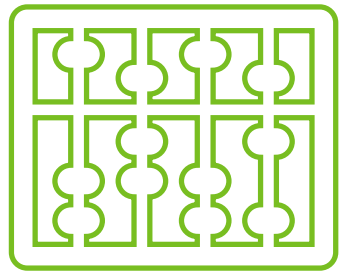


Disinvestment and underinvestment of administrative resources has led to challenges in supporting core functions.

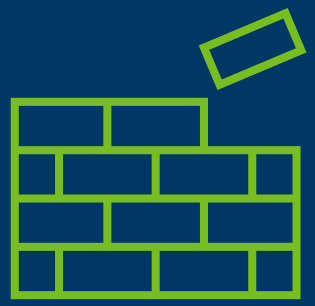
Why transform the human services system?

Operating a hybrid fee-for-service and managed care system results in siloed program integrity approaches and limited ability for the State to mitigate financial risk.

Decentralization of roles has resulted in different policies, procedures, and rules depending on where you live and who operates your benefit.



Human Services Transformation



Budget Book: Page 3

Fiscal Impact:
$16.5M in FY26/27
$54.6M in FY28/29

Transforms administration of the human services system to improve the system for people accessing support. This proposal provides the following strategies that would streamline program administration, ease local workforce challenges, provide single oversight over program policies and procedures, and ensure consistency and access to care across the state:

- Eliminates the use of Managed Care Organizations (MCOs) in Medicaid
- Shifts administration of some financial eligibility functions to the State
- Addresses MnCHOICES long-term care assessment backlogs
- Reforms Waiver Case Management by phasing out the use of contracted case management and identifying roles, responsibilities, and service rates
- Comprehensive study to develop recommendations on county, Tribal, and state roles and responsibilities in administering human services programs

Eliminate the Use of Managed Care Organizations (MCOs)

Currently

- 45% of spending and 80% of basic care is paid for through managed care, where the state pays a monthly capitation payment and the MCO pays claims
- MCOs set their own rates, provider network, prior authorization and billing requirements, and program integrity processes
- Financial, and integrity risks, fall on the state

Proposal

- Beginning January 1, 2029, transitions MA to a single Administrative Service Organization (ASO) model
- The ASO will be responsible for administrative functions related to healthcare claims
- The state will maintain all policy decision making

Outcomes

People will access the same provider network, rules, and processes, eliminating complexity and access barriers.

The State, and legislature, sets policy decisions for the Medicaid program.

The State, and legislature, can better influence spending and mitigate financial risk.

The State can better incorporate program integrity processes across the whole program rather than in siloed approaches.

Shifting MA Eligibility Functions

Currently

- Minnesota is one of 10 states with a state-supervised, county-administered human services system
- Counties and some Tribal Nations are responsible for determining a person's eligibility for Medicaid
- Challenges: Increased complexity, aging systems, large caseloads, and unfunded federal mandates

Proposal

- Beginning July 1, 2028, transitions eligibility functions to the state through a 2-phase process
- Phase 1: State takes manual eligibility processes and special programs eligibility processing
- Phase 2: Study and recommend how remaining eligibility functions would transfer to the state

Outcomes

Ease administrative burden and reduce complexity at the county-level.

Create a more seamless enrollee experience, removing the burden of providing the same documents in multiple places.

Co-create a long-term strategy with counties and Tribes.

Help ease the MnCHOICES assessment backlog

Currently

- Counties, managed care organizations, and Tribes are responsible to conduct assessments that determine an individual's program and service eligibility
- Delays often occur due to backlogs and resource constraints in completing these assessments
- The average wait time per initial assessment exceeds the timeline requirement in law and is growing

Proposal

- Creates a new team at DHS to conduct assessments to supplement and assist lead agencies with backlogs
- DHS will support cases where MA is pending, encounter systems barriers, or don't have case management
- Establishes a workgroup to develop long-term solutions to the MnCHOICES assessment process

Outcomes

Support counties in completing MnCHOICES assessments, easing access barriers for people seeking support.

Collect comprehensive, statewide information on MnCHOICES assessment processes to identify solutions to addressing MnCHOICES backlogs.

Co-create a long-term strategy with counties and Tribes.

Reform Waiver Case Management

Currently

- Waiver case managers are responsible for developing a person's support plan and ensuring that services meet the person's needs
- High case loads, unclear expectations, high turnover, low reimbursement, and increases in acuity and complex conditions
- Many counties and MCOs utilize contracted case management, resulting in varying enrollee experience and inconsistent oversight and expectations

Proposal

- Study to provide recommendations on the roles, responsibilities, and oversight requirements of waiver case management, as well as a new rate methodology to align rates with costs. Report will be submitted prior to the 2029 legislative session.
- Phase out of contracted case management by July 1, 2031.

Outcomes

Consistent oversight and expectations, improving the experience for people receiving services.

Waiver case management will be financed with a rate methodology that aligns with costs to provide the service.

Long-term roadmap for human services transformation

Objective: Conduct a comprehensive study on the role of the state, counties, and Tribal Nations in administering human services programs. Recommend changes to transform how human services are administered to the legislature in the 2029 legislative session.

Components of the Study

- Assess current roles and responsibilities
- Assess how other states administer human services, focusing on the roles of local governments versus state agencies
- 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
- Recommendations will include financing strategies and must consider workforce, systems, and timing considerations

Scope

- **DHS:** All programs and functions administered by DHS, including Medicaid, MinnesotaCare, behavioral health, housing programs, economic assistance, and licensing and oversight
- **DCYF:** Provider licensing functions, Fraud Prevention Investigation program, economic assistance programs, child support, and CCAP

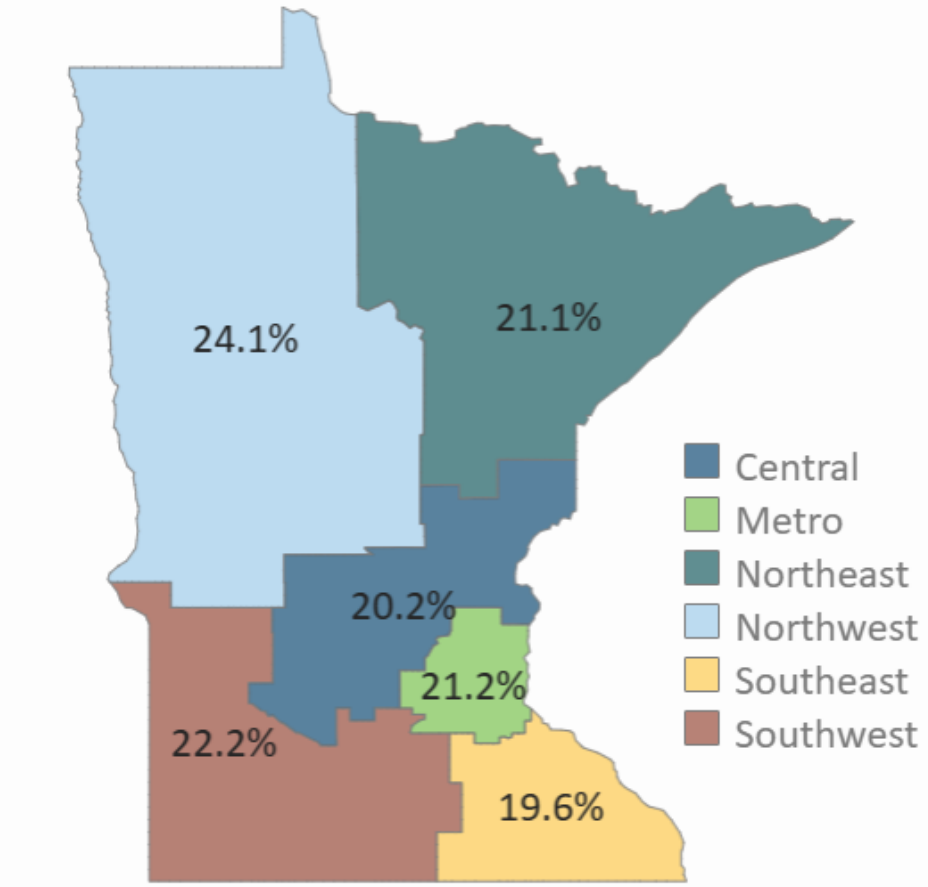
Responding to Federal Action

HR1 will impact all areas of the state and thousands of Minnesotans

On July 4, 2025, Congress passed H.R. 1 which made sweeping changes to Medicaid that will impact all corners of the state and thousands of Minnesotans. These changes will:

- Result in loss of health care coverage for Minnesotans
- Increase uncompensated care for providers and hospitals
- Increase complexity in accessing and administering MA
- Reduce federal funding to states

This budget seeks to mitigate impacts to eligible Minnesotans, minimize burden on local governments, and provide strategies to effectuate aggressive federal implementation timelines.



Percent of people receiving MA

Medical Assistance Eligibility Changes Due to HR-1

Budget Book: Page 13

Fiscal Impact:
$124k in FY26/27
-$36.5M in FY28/29

Provides statutory changes and funding to comply with new Medicaid eligibility requirements from the 2025 federal budget reconciliation bill (H.R. 1). Components of this proposal include:

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

Medical Assistance Eligibility Changes Due to HR-1 *(cont.)*

Six-month eligibility renewals for certain Medicaid enrollees

Effective January 1, 2027, states must conduct eligibility redeterminations every six months for adult expansion enrollees who are not American Indian/Alaska Natives. Currently, renewals are conducted annually.

This proposal conforms state law with this requirement and provides Navigator funding and DHS administrative resources to implement.

Obtaining enrollee address information

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.

This proposal conforms state law with this requirement and provides administrative funding to implement.

Medical Assistance Eligibility Changes Due to HR-1 *(cont.)*

Work Requirements

Effective January 1, 2027, MA applicants and enrollees who are ages 21-64, who do not have children, are not pregnant and not seeking MA based on disability, also known as Minnesota's expansion population, will be subject to work/community engagement requirements if they do not meet an exemption.

This proposal conforms state law with these requirements and provides funding to implement this provision, including utilizing an external vendor to assist counties and the state in processing this change within the eligibility process.

Total Fiscal Impact of Work Requirements, 6-Month Renewals and Obtaining Address Information:
$11M in FY27 and $33.7M in FY28/29

Medical Assistance Eligibility Changes Due to HR-1 *(cont.)*

Limit retroactive Medicaid coverage

Current state law allows up to three months of retroactive coverage prior to the month of application. HR1 limited the federal retroactive coverage period to one month before the date of application for the adult expansion population and two months for all other Medicaid eligibility groups. The February forecast assumes the additional months are paid for with all state funds.

This proposal modifies state law to align with the HR1-specified retroactive periods covered by a federal match.

Total Fiscal Impact of Limiting Retroactive Coverage:
-$10.9M in FY27 and -$70.1M in FY28/29

HR-1 Financing Related Response

Budget Book: Page 28

Fiscal Impact:
$1.3M in FY26/27
$1.7M in FY28/29

Statutory changes and funding to conform with the following financial provisions of federal legislation HR-1. Components include:

- Implements MA cost-sharing for enrollees who are adults without children with incomes between 100 and 133% of federal poverty level
- Strengthens Medicaid program oversight and support for county and tribal nation partners to increase eligibility determination accuracy and audit preparedness
- Establishes 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)
- Technical change related to the MinnesotaCare Provider Tax.

HR.1 Provision by Effective Date

July 4, 2025

* Provider Tax Statistical Test Changes

October 1, 2026

* Reduced funding for Emergency Medical Assistance
* **Legal noncitizen changes**
* **New provider tax restrictions**

January 1, 2027

* **Work requirements**
* **Six-month renewals**
* **Retroactive eligibility changes**

January 1, 2028

* Phase down of State Directed Payments by 10 percentage points annually begins

October 1, 2028

* **Reinstate cost sharing**
* Safe harbor limit for provider taxes begins to phase down

October 1, 2029

* **Medicaid payment errors changes**

Budget Neutral Proposals

Budget Neutral Proposals

Rural Emergency Hospital Payment Methodology Technical Change (Budget Book: Page 129)
Establishes a Medical Assistance rate methodology for critical access hospitals (CAHs) that convert to rural emergency hospitals (REHs).

Updates to Hospital Directed Payment Program (Budget Book: Page 131)
Technical changes to the statewide hospital directed payment program that was established during the 2025 legislative session to conform statute with legislative intent and current department policy on the implementation of the directed payment program.

Modifying the Definition of Residency for Non-Title IV-E Foster Children (Budget Book: Page 139)
Allows children in foster care who are placed in a MN 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 MA eligibility.

Budget Neutral Proposals

Sunset Supplemental Payment for Hennepin County Mental Health Clinic (Budget Book: Page 137)
Provides 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).

Budget Technical Changes (Budget Book: Page 146)
Incorporates technical changes within the accounting structure, technical language corrections, carryforward authority language, and specifying direct payments for Tribal and county governments.

DEPARTMENT OF HUMAN SERVICES

Thank You!

For more information:

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