Implementation Updates

Human Services Finance and Policy Committee
2/18/26

DEPARTMENT OF HUMAN SERVICES

DHS Updates Since 2025 Session

- Final splitting of DHS into 3 separate agencies (DHS, DCYF, and DCT)
- Responding to federal changes
- Implementing 2025 legislative session changes
- Program integrity actions

Federal Pressures

H.R. 1

On July 4, 2025, Congress passed H.R. 1 which made sweeping changes to Medicaid.

These changes will:

- Increase complexity in accessing and administering MA
- Increase uncompensated care for providers, particularly for hospitals
- Reduce federal funding to states
- Require careful planning and systems changes to implement by federally required deadlines

Changes include, but are not limited to:

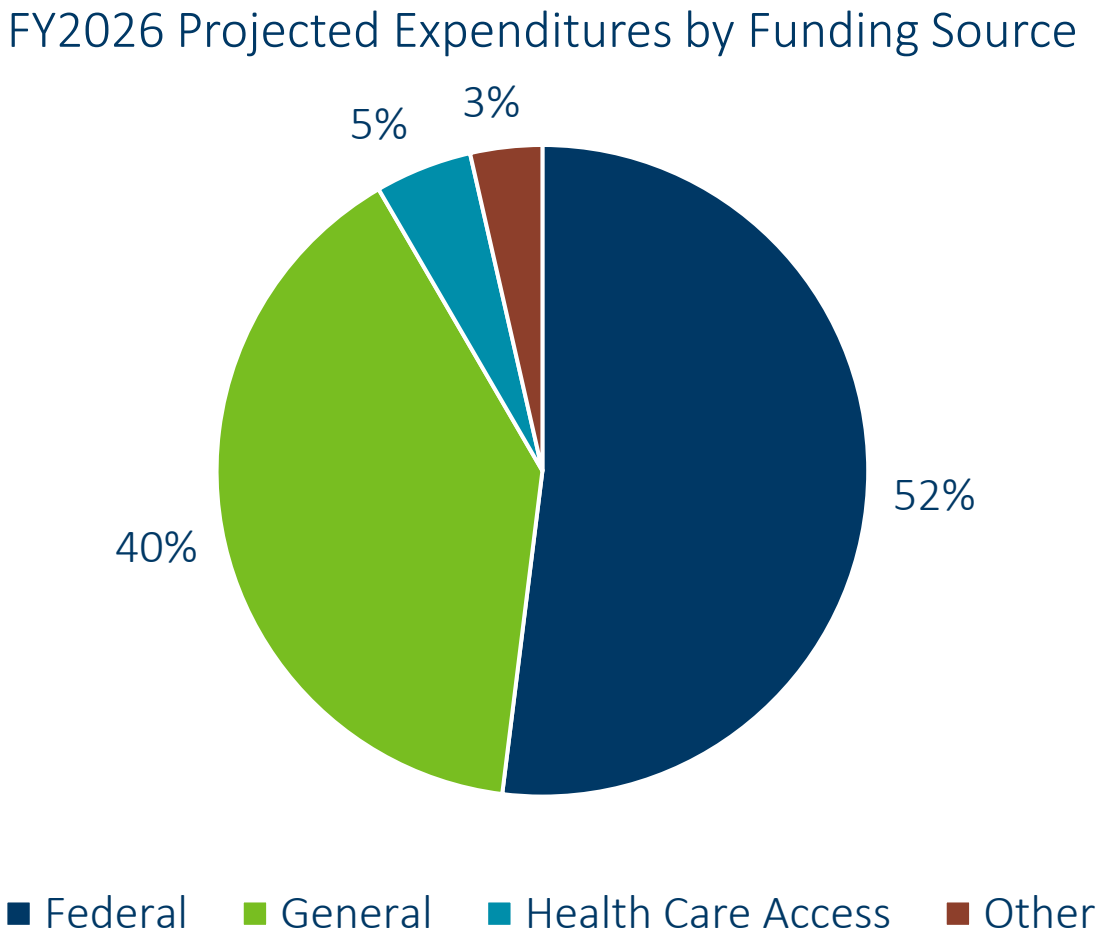
- Work requirements for some populations
- 6-month renewals for some populations
- Cost sharing requirements for some people
- Changing the retroactive MA coverage period
- Changing eligibility criteria for people with lawful immigration statuses
- Changing federal funding for certain services and populations on MA & MnCare
- Limitations on health care taxes

Federal Pressures

Funding Pressures and Volatility

- Federal government shutdown(s) required the State to monitor financial risk
- Interruptions in federal grants, modified terms of grant dollars, and inconsistent federal guidance
- Changes in how MA state plan and waiver amendment requests are scrutinized
- Risks of federal withhold of payments:
  - CMS indicated they intend to withhold $515 million per quarter in future federal funding
  - DHS has submitted an administrative appeal, which is currently pending
  - $515M per quarter is about $2.06 billion per year, about double what the human services savings target was last session that spanned across four years ($1.09B)
- Risks of federal deferral of payments:
  - CMS has also indicated they may undertake a separate process called a deferral, which reviews claims already reimbursed to the State
  - The scope, timing, and resolution of the deferral is unknown

More than half of DHS' budget comes from federal sources



FY2026 Total Projected Spending:

- Federal: $14.1B
- General Fund: $10.8B
- HCAF: $1.3B
- Other: $969M

Total: **$27.98B**

Preserving Medicaid

Medicaid is the largest single source of health insurance in Minnesota.

Medicaid, known as Medical Assistance in Minnesota, covers more people in the state than Medicare and more people than any single commercial insurer. That means Medical Assistance plays a key role in the state's all-time low uninsurance rate of 3.8%

Medicaid serves as the foundation of Minnesota's health care infrastructure.

Medicaid contributes significantly to the state's health care sector, supporting hospitals, mental health centers, home care, community clinics, nursing homes, physicians, dentists and many other health professionals. It serves as a lifeline to Greater Minnesota providers. Medicaid decreases the cost of uncompensated care that can threaten a clinic or hospital's sustainability and reduces the amount of medical debt owed by Minnesotans.

Minnesota's health care tops other states.

We invest in the health of our communities through Medicaid, and it shows. Health care quality varies widely across the United States, and Minnesota consistently outperforms other states.

2025 Session Implementation

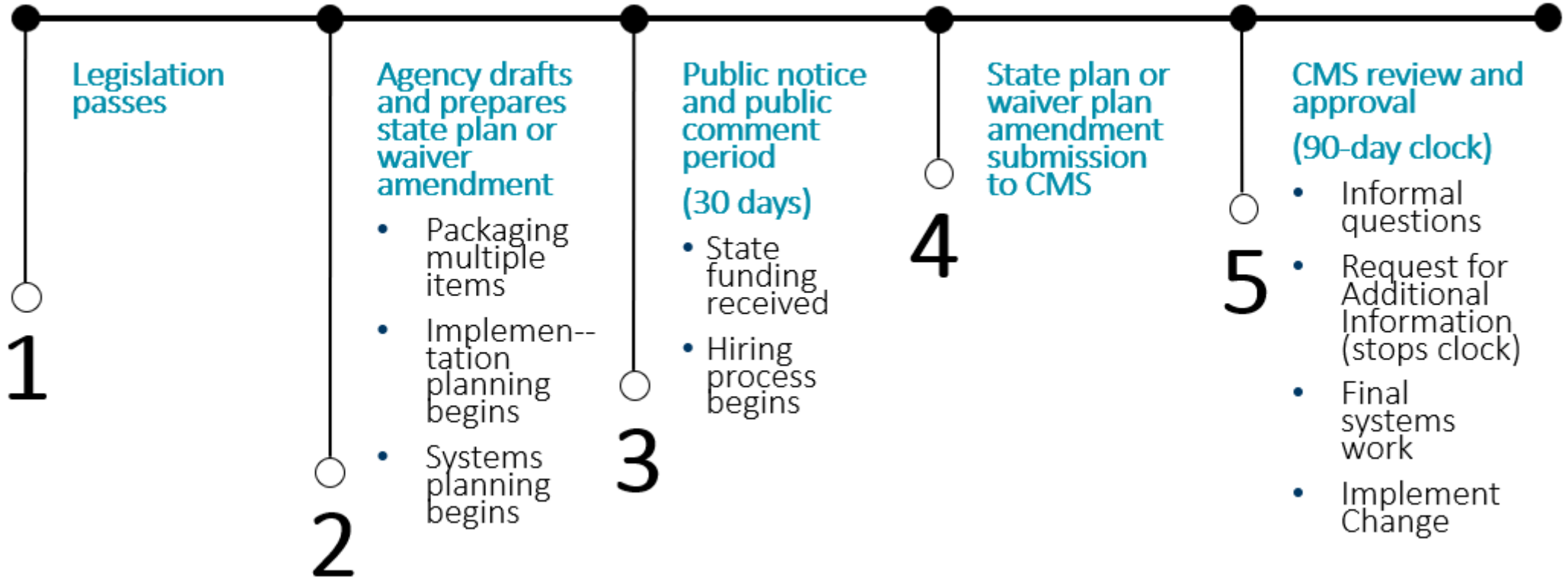
Human Services Budget Bill (Chapter 9)

- **Net GF Impact**: -$270M in FY26/27 and -$820M in FY28/29
- **DHS GF Impact**: -$285M in FY26/27 and -$938M in FY28/29
- Over 57 budget items for DHS in the spreadsheet, many of which had multiple components

Health & Human Services Budget Bill (Chapter 3)

- **Net GF Impact**: -$98M in FY26/27 and -$298M in FY28/29
- **DHS GF Impact**: -$69M in FY26/27 and -$273M in FY28/29
- Over 47 budget items for DHS in the spreadsheet, many of which had multiple components

Federal Approval Process



Nursing Facility Changes

Change	Target Eff. Date	Implementation Status
Patient-Driven Payment Model (PDPM)	October 1, 2025	Implemented 10/1/2025
Repeal automatic annual Alternative Payment System (APS) property rate inflation	January 1, 2026	Pending CMS review and approval
Operating Cap Indexed to CPI-U (or 4%)	January 1, 2026	Pending CMS review and approval
Surcharge and Add-On Changes	January 1, 2026	Pending CMS review and approval. End date expected due to HR1.
Nursing Home Workforce Standards Board	January 1, 2026	Pending CMS review and approval
Phase out Single Bed Incentives	January 1, 2027	Will submit in future SPA
Eliminate Layaway Rate Add-Ons	January 1, 2027	Will submit in future SPA

MnChoices Changes

Change	Target Eff. Date	Implementation Status
Attestation to no changes in needs or services (ages 21-64)	January 1, 2026	Pending CMS review and approval. Delayed effective date expected.
Use of MnChoices certified assessors in hospitals via contracts with counties	January 1, 2026	CMS approved EW amendments, waiting on disability amendment approval before implementing. Delayed effective date expected.
MnChoices assessor qualifications, training, certification – removal of bachelor's requirement	January 1, 2026	CMS approved EW amendments, waiting on disability amendment approval before implementing. Delayed effective date expected.
MnChoices verbal attestation or alternative to replace required assessment signatures	January 1, 2026	CMS denied this language in the EW amendment, therefore will not be implemented.

Home & Community Based Services - Investments

Change	Target Eff. Date	Implementation Status
CFSS rate changes as a result of the SEIU agreement	January 1, 2026	Pending CMS review and approval. Received RAI from CMS and responded.
Allow Reimbursement of CFSS in Acute Care Hospital Settings	January 1, 2026	Will be in future amendment package. Delayed effective date expected.
Swimming Lessons as Allowable Uses in CDCS and CFSS	January 1, 2026	Disability Waivers: Pending CMS review and approval. Delayed effective date expected. CFSS: No amendment is required. DHS in process of updating policy pages.
Modify Out of Home Respite Services	January 1, 2026	Pending CMS review and approval. Delayed effective date expected.
Added new budget exception for older adults eligible for EW and discharging hospital	January 1, 2026	CMS approved, DHS implemented on schedule.

Home & Community Based Services - Savings

Change	Target Eff. Date	Implementation Status
Changes to DWRS Inflationary Adjustments	January 1, 2026	Pending CMS review and approval. Delayed effective date expected.
Daily cap on Individualized Home Supports with Training	January 1, 2026	Pending CMS review and approval. Delayed effective date expected.
Asleep Night Supervision Rate	January 1, 2026	Pending CMS review and approval. Delayed effective date expected.
Limit DWRS Rate Exceptions	July 1, 2026	DHS preparing for 7/1 implementation
Disability waiver authorization reform	January 1, 2026	Pending CMS review and approval. Delayed effective date expected
Family Residential Services rate changes	January 1, 2026	Pending CMS review and approval. Delayed effective date expected. Life Sharing service in future amendment package.
LTSS Advisory Committee	October 1, 2025	LTSS Advisory Committee started in October 2025.

Behavioral Health Changes

Change	Target Eff. Date	Implementation Status
Substance Use Disorder (SUD) Rate Increases	January 1, 2026	SPA approved and implemented
SUD Service Changes – Disaggregating individual and group counseling	July 1, 2026	Posting for public comment in Feb; likely will be submitted to CMS in March/April
Opioid Treatment Program (OTP) Rate Changes (2023 law)	January 1, 2026	Pending CMS review and approval. Implementation is also delayed due to systems work
Mental Health Targeted Case Management Rate for Individuals 18-21 years	July 1, 2025	Delayed due to systems work
1115 Reentry Demonstration Waiver	January 1, 2027	Target approval date in June 2026
Traditional Healing 1115 Demonstration Waiver	January 1, 2027	Waiver is being drafted. DHS working with Tribes to design benefit, with goal to post for public comment in March and submit to CMS in April/May

DHS Program Integrity | EIDBI

What is EIDBI?

The purpose of the EIDBI Benefit is to provide medically necessary early intensive intervention for people with Autism Spectrum Disorder (ASD) and related conditions, as well as:

- Educate, train and support parents and families.
- Promote people's independence and participation in family, school, and community life.
- Improve long-term outcomes and the quality of life for people and their families.

See Minnesota statutes §256B.0949

Licensure Study

- DHS has recommended EIDBI reforms and collaborated with the Legislature over the years.
- In 2023, DHS recommended a licensure study and community engagement to get feedback on regulatory recommendations.
- In 2024 DHS completed a 3-part study and extensive community engagement. This work culminated in a final report and licensure recommendations in January 2025.

First phase:

February 2024. Conducted in collaboration with Community Research Solutions.

see Minnesota Early Intensive Developmental Behavioral Intervention (EIDBI) Benefit Set: Review of human services licensing guidelines (PDF)

Second phase:

August 2024. Conducted in collaboration with Courageous Change Collective.

see Minnesota Early Intensive Developmental Behavioral Intervention (EIDBI) Benefit Set: Review of human services licensing guidelines (PDF)

Third phase:

Conducted in collaboration with Katie Burns 10,000 Lakes Consulting.

See EIDBI Licensing recommendations Legislative Report

Summary of recommendations

- Minnesota should adopt a system of licensure to enhance oversight of EIDBI services while balancing access to services.
- Licensure should include health and safety standards tailored to the environment where services are delivered.
- Licensure should include authority for DHS to investigate, report, and act on alleged violations of program standards.
- Licensure should include clinical oversight requirements, provider supervision standards, and training.

EIDBI Provisional Licensure

- The 2025 Legislature established an EIDBI provisional licensure. Key components of the licensure include DHS authority to:
  - Enter the physical premises of an agency without advance notice;
  - Investigate maltreatment reports and complaints against agencies
  - Issue corrective actions and sanctions (revocation, fines, injunctions)
  - Beginning 1/1/2026 DHS must begin issuing provisional licenses and EIDBI agencies have until 5/31/26 to submit an application.
  - DHS must determine if a provisional license applicant complies with all requirements and either issue a provisional license or deny the application by 12/31/26.
- DHS must collaborate with the EIDBI Advisory council to develop comprehensive licensure recommendations and propose standards for non-provisional, comprehensive licensure requirements by 1/1/2027.

Provisional Licensure Implementation Update

- The Provisional license application launched 1/2026
  - Received 5 complete applications as of mid-February
- DHS submitted EIDBI provider enrollment moratorium to CMS 8/1/25 and it was approved with an 11/1/25 effective date.
- DHS is in the final stages of developing dashboards to monitor counts of applications received, licenses issued, and enrolled agencies “yet to apply”
- EIDBI Licensing Unit hiring is in progress; 8 licensor positions will be filled
- Parallel to implementation of the provisional license, DHS is developing comprehensive standards for the 2027 session

Provisional License External Engagement

- DHS developed community engagement and communications plans
- EIDBI Advisory Council
  - Presented information about provisional licensure on Aug. 1, DHS continues to collaborate with Council
- Communication sent to EIDBI agencies
  - Notification about timelines related to provisional licensure
- Licensing website established, which includes:
  - A listserv sign up for email updates
  - An email address for questions about provisional licensure
  - Frequently asked questions

Strengthened Oversight

- In addition to licensure, DHS recommended changes to strengthen clinical and operational requirements, ensuring high-quality service and better outcomes for children and families.
  - Revalidation frequency was increased to every three years
  - Enhanced EIDBI background studies
  - Required qualified supervising professionals to be employee of agencies
  - Modified the list of approved treatment modalities
  - Required clinical supervision for a minimum of one hour for every 16 hours of direct treatment per person, unless otherwise authorized in the person's individual treatment plan.

DEPARTMENT OF HUMAN SERVICES

Thank You!