The Long-Term Care IMPERATIVE

A Minnesota Collaboration for Changes in Older Adult Services

April 28, 2026

TO: Members of the Ways and Means Committee
RE: HF 4338 & HF729

Chairs and Members of the Committee,

On behalf of the Long-Term Care Imperative, a collaboration between Care Providers of Minnesota and LeadingAge Minnesota, we are writing to highlight areas of support and areas of concerns that long-term care operators have with House File 4338 and HF729.

Appreciation

HF4338; Human Services Finance Bill

- First, we appreciate inclusion of the underlying components of the original bill, as identified in Article 7. These budget neutral provisions will support red tape relief for assisted living providers and the residents in their care.
- We also are grateful that the HF4338 does not adopt the Governor's proposed cuts to long-term care, including additional reductions to nursing homes' operating caps, reducing quality incentive programs, cutting employee health insurance, and eliminating the PCRA program. Without an approved State Plan Amendment, now is not the time to further cut nursing homes who continue to operate without 2026 rates.
- We appreciate establishing an appeal process for providers to enroll in Minnesota's Medicaid program in the event of a statewide or regional moratorium in Article 6, sec. 16. This would better preserve accessibility of services based on an identified need by geography, specialty population, or related continuity of care considerations.

HF729, Human Services Policy Bill

We appreciated the opportunity to work with the Dept. of Health and advocates over the interim. Since last session, we have been able to work through many of our concerns and are neutral on the language due to these changes:

- The language of the bill now specifies that training is not required for facilities that have a policy prohibiting the use restraints within their settings;
- The language of the bill now clarifies that use of restraints by others, including law enforcement or emergency personnel, are not the reporting responsibility of the facility; and
- It aligns reporting obligations of emergency use of restraints to be consistent with existing reporting obligations in state law.
- Resolved concerns about resident initiated use of a restraint device, such as a bed rail

HF 4338 Concerns:

We are concerned that several provisions in this bill could have the unintended consequence of reducing access to care and destabilizing an already fragile long-term care system. We ask members to reconsider these aspects of the proposal.

- **Article 6, Section 22.** The moratorium on new providers of Customized Living and 24-Hour Customized Living is concerning for long-term care providers. We understand the intention is to avoid rapid growth due to a recent change prompted by CMS and the State Planned Amendment process within the CADI/BI provider groups. However, the broad approach and with the understanding that moratoriums of new providers, even with exemptions, effectively end development of new service options. This could result in keeping new Elderly Waiver customized living participants from the market – just as we have more seniors than children in K-12 and the needs continue to grow.
- **Article 6, Sections 6-9:** We appreciate that this section recognizes a need for flexibility in verifying participation in various HCBS services, including the use of electronic visit verification. We believe there are additional flexibilities that maintain appropriate internal controls while minimizing the operational (and not just financial) burden of compliance for enrolled providers. We welcome the opportunity to work with legislators to refine this section as it moves forward.
- **Article 6, sec. 23**: These sections' staffing documentation and auditing requirements, while well intentioned, fail to reflect how services are delivered in assisted living settings. MnCHOICES assessments rely on time-based assumptions that do not accurately capture the realities of care delivery. Services are often not provided on a one-to-one basis and would require estimation or proration across multiple residents. Attempts to reconcile actual service time with assessment assumptions will likely produce inconsistent data across providers. This inconsistency is especially concerning given that the proposal intends to use this data to inform rate adjustments. It is also unclear in this language whether these reporting requirements are limited to high-risk programs, applied to Medicaid recipients broadly, or applied to all clients receiving services from a provider regardless of their payer source.

Minnesota lawmakers have a responsibility to ensure access to care for the state's most vulnerable residents. We ask that legislators and DHS work with the industry to ensure program integrity while avoiding inadvertently limiting the availability of care and services Minnesota seniors deserve.

Respectfully submitted,

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LeadingAge MN
LTC Imperative member

Kyle Berndt
Care Providers MN
LTC Imperative member

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April 28, 2026

Dear Co-Chairs Torkelson and Frazier,

Thank you for accepting these comments on HF 729.

Fraser is a Minnesota-based nonprofit with over 90 years of experience. We also are the largest and oldest autism provider in the state. We are an Essential Community Provider that delivers a variety of disability and behavioral health services to individuals from across the state. In the past year, we served children, adults, and families in each of the districts of the members on the Ways and Means committee.

We appreciate the opportunity to comment on the proposed EIDBI policy changes (located on lines to 80.7 to 87.3). This collection of proposals could introduce significant new changes to EIDBI, including new standards around Observation and Direction services, clinical supervision, and clinical documentation.

EIDBI has received multiple well-intended statute changes the past several sessions, as well as well-intended policy clarifications between sessions. We are growing increasingly uncomfortable that these changes are creating confusion and unintended impacts that are quickly compounding. We are concerned that adding even more changes again this session without a comprehensive plan for EIDBI will likely lead to even more unintended impacts. Our preference is that all proposed changes to this critical program please go through more community input and instead be brought forward as part of the EIDBI licensing proposal scheduled to be presented to the state legislature next year.

If that is not possible, we would appreciate additional conversation before the end of session to make the proposed changes more workable. Some examples of possible improvements are: 1) Please expand the definition of clinical supervision to include all activities where the Qualified Supervising Professional has direct contact with the client, including intervention. 2) Please align the EIDBI documentation requirements to more closely match the standards for other similar clinical services. 3) Please add additional clarification to more clearly confirm that Level 2 providers can continue to provide Observation and Direction services (in addition to the monthly Observation and Direction that must be provided by a Qualified Supervising Professional or Level 1 provider).

Thank you again for considering our comments.

Sincerely,

Lucas Kunach
Director of Business Development
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