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,

Erin Huppert
LeadingAge MN
LTC Imperative member

Kyle Berndt
Care Providers MN
LTC Imperative member

The Invisible Crisis in Children's Family Residential Services

A Frontline Perspective from a Minnesota County Child Foster Care Licensor

The conversation about Family Residential Services has, until now, focused largely on adults. The voices of those serving Minnesota's children with disabilities have been missing. The following perspective comes from a county child foster care licensor who specifically works with providers holding both child foster care and 245D licenses. **Names and county have been withheld at the licensor's request.**

> *"Adults deserve choice, and family care should remain available for them. But children need a family."*
>
> A Minnesota county child foster care licensor

Children Need Families, Not Residences

So many youth with disabilities need care in a family setting. Sometimes these are voluntary long-term placements. But often these youth re-unify with parents, go to relatives, or are adopted. Family child providers do not have a built-in 30-year-plus income source when they accept a youth into their homes. Sometimes it works that way. Sometimes it does not.

Family providers are essential for community integration. Youth become members of extended families, and often return for holidays, visits, to introduce their spouses, or to call when they are struggling well into adulthood. Family providers are mentors to children's biological families, and successful reunification with parents often happens because foster parents provide informal, unbilled support long after a youth leaves care.

Family Providers Are a Bargain for Taxpayers

Of three corporate child foster care providers in this county, two require an approved exception rate before accepting a placement. When environmental adaptations are required, corporate providers seek additional taxpayer funding.

Family providers, by contrast, install elevators, stair lifts, and full sensory rooms from the FRS payment alone. They hire staff who provide coverage when youth have appointments, miss school, or attend visits with family. They do this work with love and compassion.

> *"Of three corporate providers in this county, two require an approved exception rate before accepting a placement. Family providers install elevators and sensory rooms from the FRS payment alone."*
>
> Documented in this licensor's caseload

Family Providers Take the Calls Corporate Providers Will Not

Family child foster care providers are the ones counties call at 4:30 on a Friday afternoon to accept a youth in emergency county custody, a youth who does not have a waiver, has not been SMRT'd, has not seen a doctor or dentist.

These providers work with county workers to arrange and coordinate assessments, referrals for therapy, and other supports without any waiver payment until that screening is approved. Sometimes that approval takes weeks. Sometimes months. No corporate, shift-staff provider will do that.

The Harm Has Already Started

> **Tiered rates have already caused displacement.**
> In this licensor's county alone, the tiering of rates has already caused the displacement of one youth from family care. The licensor and county are working to keep that child in family placement, but the financial pressure on family providers is already producing real, measurable harm to children.

If Family Providers Close, Where Do Children Go?

The fact is youth in need of placement with disabilities will be left in dangerous situations. They cannot legally be cared for in emergency shelters. They cannot be placed in homes with multiple children. The system has no backup.

This is going to devastate an already vulnerable service.

What This Means for Both Omnibus Bills

In the Senate, Amendment A20 to SF 4476 provides selective rate increases for some assessment levels. It does not address the structural problem. It does not protect children's residential services.

In the House, HF 4338 contains no FRS amendment at all. HF 4288 has not yet been moved forward.

Reenacting the DWRS framework rate methodology, as proposed in SF 4310 and HF 4288, is the only correction that protects both adult and children's Family Residential Services. The Senate must amend A20 to do this. The House must add an amendment to HF 4338 to do the same. **The cost of inaction will fall hardest on the children who most need a family.**

Adult Foster Care Capacity in Minnesota

Licensed Residences and Available Beds, September 2024 through April 2026

The Story in Three Numbers

285
Fewer beds since September 2024

72
Fewer licensed residences

65
Homes closed since September 2025

This brief tracks Adult Foster Care (AFC) license capacity in Minnesota over an 18-month window. The data is drawn from the DHS Licensing Information Lookup at three points: September 2024, March 2025, and April 2026. The trend is consistent and worsening: fewer homes, fewer beds, and accelerating closures of the multi-bed residences that serve Minnesotans with the most complex needs.

Snapshot 1: September 2024

September 2024

Active AFC Licenses: **1,162** Total Available Beds: **2,778**

Licensed Capacity	Number of Residences	Percent of Total	Total Beds
1 bed	344	29.6%	344
2 beds	348	29.9%	696
3 beds	190	16.4%	570
4 beds	232	20.0%	928
5 beds	48	4.1%	240

Source: DHS Licensing Information Lookup, accessed September 2024, https://licensinglookup.dhs.state.mn.us/

Snapshot 2: March 2025

March 2025

Active AFC Licenses: **1,137** Total Available Beds: **2,659**

Licensed Capacity	Number of Residences	Percent of Total	Total Beds
1 bed	356	31.3%	356
2 beds	340	29.9%	680
3 beds	182	16.0%	546
4 beds	213	18.7%	852
5 beds	45	4.0%	225

Source: DHS Licensing Information Lookup, accessed March 13, 2025, https://licensinglookup.dhs.state.mn.us/

Snapshot 3: April 2026

April 2026

Active AFC Licenses: **1,090** Total Available Beds: **2,493**

Licensed Capacity	Number of Residences	Percent of Total	Total Beds
1 bed	357	32.8%	357
2 beds	330	30.3%	660
3 beds	172	15.8%	516
4 beds	195	17.8%	780
5 beds	36	3.3%	180

Source: DHS Licensing Information Lookup, accessed April 5, 2026, https://licensinglookup.dhs.state.mn.us/

What Changed Between September 2024 and April 2026

The largest losses are concentrated in 5-bed and 4-bed homes. Single-bed homes increased slightly during the same period. Capacity is consolidating into smaller homes.

License Category	Net Change	Percent Change
5-bed homes	**-12**	**-25.0%**

License Category	Net Change	Percent Change
4-bed homes	**-37**	**-16.0%**
3-bed homes	**-18**	**-9.5%**
2-bed homes	**-18**	**-5.2%**
1-bed homes	**+13**	**+3.8%**
Total beds	**-285**	**-10.3%**

Smaller Homes Cost More to Operate Per Resident

Over the 18-month window, the share of beds located in 3-bed-or-larger residences declined from 62.6% to 59.2%. This shift toward smaller homes does not reduce the cost of providing care. It increases it.

Family Residential Services homes operate on shared staffing. The fixed cost of base staffing, overnight coverage, transportation, programming, and administrative overhead is divided among the residents the home serves. A 5-bed home spreads those fixed costs across five people. A 1-bed home absorbs a similar minimum overhead with only one resident to help carry it.

As multi-bed homes close and capacity consolidates into 1-bed and 2-bed homes, the per-resident cost of providing care goes up. The flat rate, which assumes a static distribution of bed sizes, does not account for this dynamic. The result is a system that is becoming structurally more expensive to operate while serving fewer people.

Time Point	Beds in 3+ Bed Homes	Share of All Beds
September 2024	1,738	**62.6%**
March 2025	1,623	**61.0%**
April 2026	1,476	**59.2%**

The Pace of Closure Is Accelerating

> 65 AFC homes have closed since September 2025.
> The 65 closures tracked here count only Adult Foster Care licenses. Closures in children's family foster care are also occurring, which means the actual loss across both license categories is larger.

> Closures are not slowing. Under the flat rate methodology now in effect, modeling indicates up to 70% of remaining homes could be forced to close.
>
> If realized, displacement on this scale would not be a possibility to manage. It would be a crisis to absorb.

Why This Matters

Adult Foster Care is one piece of Minnesota's residential service system, and the bed counts above represent real people. Each closed home is a household displaced. Each closure forces a placement decision.

Displaced residents must go somewhere. The alternatives, most often Community Residential Settings or institutional placements, cost the state significantly more than the AFC home that was lost. The closures tracked here are not producing savings. They are producing higher downstream spending and reduced capacity at the same time.

Methodology

All counts above are drawn directly from the Minnesota Department of Human Services Licensing Information Lookup tool. The lookup tool reflects active licenses at the time of query. License data was retrieved on September 2024, March 13, 2025, and April 5, 2026. Closure counts reflect active license terminations between snapshots.

> **Prepared by the Minnesota Association of Residential Service Homes**
> MARSH represents licensed Adult Foster Care and Family Residential Services providers across Minnesota. For questions, additional data, or media inquiries, contact admin@marshmn.org.

Chair Schomacker and Members of the Committee,

My name is Sandra Bond, and I am the President of MARSH, the Minnesota Association of Residential Service Homes.

Thank you for your time and for your continued commitment to the individuals and families who rely on these services.

I am writing today with urgency to ask you to create an amendment in the Human Services Supplemental Finance Bill to return Family Residential Services (FRS) to the Disability Waiver Rate System (DWRS).

FRS is currently the only one of the 18 HCBS waiver programs being removed from DWRS. That inconsistency is not just a policy issue—it is already creating real and immediate harm.

Family Residential Services are fundamentally different from traditional models of care. They support individuals with complex medical, developmental, and mental health needs in real family homes. These are not shift-based environments. They are homes where people live with consistency, form deep relationships, and experience true belonging.

In adult settings, this model provides high-acuity, often hospital-level care in a stable, relational environment. When this model is lost, individuals do not just lose a placement—they lose their home, their caregivers, and often the only consistent relationships they have known.

Providers across the state are already finding this model unsustainable under a flat rate structure that does not account for the intensity or variability of care. As a result, programs are closing or being forced to transition into models that fundamentally change the nature of care.

And the impact does not stop with adults.

We have now learned from a county licensor, that children in family foster care settings are also being affected. In their email, they note:

- Family providers are the backbone of care for youth with disabilities. They are the ones who accept emergency placements when no one else will. They care for children without immediate funding, coordinate medical and therapeutic services, and often invest their own resources to create safe, accessible homes.
- They also provide something that cannot be replicated in a rate system—lifelong relationships. These children become part of families. They return for holidays,

maintain connections into adulthood, and benefit from stability that supports both their development and, in many cases, successful reunification.

- When family providers disappear, these children have nowhere appropriate to go. Many cannot be served in shelters or institutional settings due to safety and legal limitations.

We are already seeing displacement.

This is not a future concern—it is happening now.

If this continues, we will lose a model of care that has proven to be both effective and cost-efficient. We will see increased reliance on higher-cost, corporate settings that often require exception rates and are not equipped to respond in the same way—especially in urgent or high-need situations.

Most importantly, we will see harm to the individuals and children who depend on these homes for their safety, stability, and quality of life.

We must raise our voices for those who cannot advocate for themselves and ensure that no harm comes from the implementation of the flat rate system.

Returning FRS to the DWRS framework is a necessary and immediate step. It restores consistency, acknowledges the complexity of this model, and helps preserve access to family-based care across Minnesota.

This is not about creating something new. It is about protecting something we know works.

I urge you to act.

Thank you for your time and consideration.

Sincerely,

Sandra Bond
MARSH President
651-592-7319

April 28, 2026

Dear Co-Chair Torkelson, Co-Chair Frazier and Members of the Ways and Means Committee,

This Is Medicaid is a broad and diverse coalition of more than 50 organizations from across our state, partnering to protect and strengthen Medicaid for the good of all Minnesotans. Our members serve urban, suburban, and rural communities; people with disabilities and serious or chronic health conditions; children, adults, and seniors; in other words, the people who rely on Medicaid across our great state. What unites us is our belief that Minnesota is stronger together when our communities are healthy.

Thank you for your thoughtful review of HF 4466, the Omnibus Health Budget proposal. We appreciate your attention to the fact that Minnesota will need to make changes to our state Medicaid program due to the passage of H.R. 1 (Public Law 119-21) in order to stay in compliance and preserve federal funding. However, these changes also come with significant risk of harm to our communities, and we urge you to ensure that these efforts protect access to health care coverage as much as possible.

We have concerns with two aspects of the Governor's recommendations that are included in your bill and urge you to remove them:

- **Cost-Sharing for Certain Adults on Medicaid.** While Minnesota will likely need to adopt a similar policy in the future, this federal mandate does not take effect until 2028 and the Governor's proposal goes above and beyond the basic changes needed for the state to achieve federal compliance. State Medicaid programs across the country are also still awaiting federal guidance from CMS on this topic. Holding off on this policy change until the next legislative session will allow time for genuine engagement with the community on how to implement it in the least harmful way for our state.
- **Reducing Retroactive Coverage**. Reducing months of Medicaid retroactive coverage will impose additional financial burden for Minnesotans already struggling to afford care, and shift more costs onto hospitals and providers through uncompensated care. The current state budget forecast assumes that Minnesota retains 3-months of retroactive coverage. As such, continuing the current policy of three (3) months of retroactive coverage should not require additional state investment. By not changing Minnesota's retroactive coverage policies, you are sustaining an essential lifeline to our health care system. We urge you to remove the retroactive coverage changes from your bill.

We acknowledge that many changes are necessary to adopt work reporting requirements as mandated by H.R. 1 to retain federal funding. However, this policy will almost certainly mean that Minnesotans who are eligible for Medicaid will not be able to access it due to overwhelming administrative and bureaucratic process issues - not because they do not meet the eligibility criteria. Currently in Minnesota's Medical Assistance program, 70 percent of adults covered by Medicaid are employed[1] and those who do not work are often already caring for a loved one, are in school, or face substantial barriers to work. Experiences documented from states outside of Minnesota[2] indicate that implementation of work requirements results in high administrative costs and removal of enrollees from health care who should be eligible. **It is imperative that the Minnesota Legislature does everything possible to mitigate the harm this policy will create.**

[1] https://mnbudgetproject.org/resource/work-reporting-requirements-could-lead-to-large-loss-of-health-care-coverage-across-minnesota

[2] https://www.kff.org/medicaid/understanding-the-intersection-of-medicaid-and-work-an-update/

We especially want to avoid adversely impacting people who are recovering from or living with serious diseases like cancer or other chronic illnesses. These individuals may fit the definition of someone who is perceived to be included and 'should' work, but in reality, it is often impossible for them to do so. It is important for lawmakers to understand that a narrow definition of medical frailty may not fully account for the vast array of complex health conditions that may limit a person's ability to comply with H.R. 1's work and community engagement standards. While the bill reflects a positive start, we believe more could and must be done to protect access to health care in our state. As you continue to refine language and policy proposals, **we urge lawmakers to adopt the broadest standards possible for medical frailty to protect Minnesotans' access to Medicaid coverage.**

Lastly, **please ensure that the administrative resources needed at both the state and county levels, as well as necessary IT investments, are included as an integral part of the compliance package for HR1.** These changes will bring unprecedented disruption to our health care system. Medicaid enrollees, health care providers, and administrators will all need a strong and reliable infrastructure in place to support them in navigating these changes.

Thank you,

This Is Medicaid Co-Conveners:

Kirsten Anderson
Executive Director
Aspire MN

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651-927-3694

Maeve Olson
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Fraser
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www.fraser.org

April 28, 2026

Dear Co-Chairs Torkelson and Frazier,

Thank you for accepting these comments on HF 4338.

Fraser is a Minnesota-based nonprofit with over 90 years of experience. 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 would appreciate your support of these provisions:

- **Disability case management working group** (Article 6, Section 25 starting on page 220). Thank you to Rep. Fischer and others for working so closely with stakeholders this session on this issue. We are eager for the advisory working group to begin its work of evaluating home and community-based waiver case management services and making recommendations for how to improve the quality and sustainability of this critical service.

- **Uniform Service Standards** (Article 5 starting on page 130). This article will move the next piece of Uniform Service Standards forward. Our CCBHC program in particular will benefit from the clarity and consistency that licensing will provide. We have appreciated the extensive community stakeholder engagement that DHS has conducted around Uniform Service Standards the past several years, including ongoing conversations about a few last remaining details in this large and important proposal.

Finally, we understand the rationale for including billing limits to some EIDBI services (Article 6, Section 15 starting on page 211). However, we would prefer that any further changes to EIDBI go through more community input and instead be brough forward in one unified package as part of the EIDBI licensing proposal scheduled to be presented during next year's legislative session.

Thank you again for your support of HF 4338.

Sincerely,

Lucas Kunach
Director of Business Development
612-798-8303

NAMI
National Alliance on Mental Illness
MINNESOTA

April 28, 2026

Ways and Means Committee
Centennial Office Building
658 Cedar St
St Paul, MN 55155

RE: HF 4338

Dear Chair Torkelson, Chair Frazier, and Committee Members,

Mental health needs among Minnesotans remain significant. Approximately one in five Minnesotans experience a mental illness, and about one in 20 live with a serious mental illness. In addition, roughly one in five adults report their mental health was not good for at least two weeks in the past month, underscoring the widespread need for early support and intervention. These realities highlight the importance of the committee's ongoing investments in prevention, early intervention, and school-based supports.

We are grateful for the inclusion of the next phase of Mental Health Uniform Service Standards (USS), which is a critical reform to support continued access to and expansion of mental health services in Minnesota. We are also grateful to see the inclusion of Targeted Case Management (TCM) for individuals who are incarcerated. Strengthening continuity of care during incarceration and upon reentry is key to improving outcomes and reducing recidivism.

At the same time, we respectfully share our concerns in a few key areas.

The absence of the proposal to create a **First Episode Psychosis (FEP) Medicaid benefit** is a missed opportunity. Early intervention is critical to improving long-term outcomes for young people experiencing psychosis, and investment in FEP programs has a strong evidence base.

Finally, we encourage additional investments in **school-linked behavioral health** and **mobile crisis services**. These services are critical for early intervention, reducing reliance on emergency departments, and ensuring individuals receive support in the least restrictive settings.

Thank you for your consideration.

Sincerely,

Marcus Schmit

CHC CREATING HEALTHIER COMMUNITIES

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Charities Review Council MEETS STANDARDS

Preserve Long-Standing, Trusted EIDBI Services for Children with Autism

May 4, 2026

The Honorable Mohamud Noor
Co-Chair, Human Services Finance and Policy Committee
Minnesota House of Representatives
5th Floor Centennial Office Building
St. Paul, MN 55155

The Honorable Joe Schomacker
Co-Chair, Human Services Finance and Policy Committee
Minnesota House of Representatives
2nd Floor Centennial Office Building
St. Paul, MN 55155

Re: HF4338 Program Integrity bill

Dear Co-Chairs Noor and Schomacker, and Members of the Committee:

The members of the Autism Treatment Association of Minnesota (ATAM) express our serious concerns regarding certain proposed changes in law that would impact the availability of Early Intensive Developmental and Behavioral Interventions (EIDBI) services. These proposals are being rushed into law as part of HF4338 and its Senate companion without proper study. The unintended consequences of the changes are likely to severely disrupt the sound and ethical services to the needy children of Minnesota. The resulting costs of the failures will be borne by families, school districts, and emergency rooms.

ATAM members do fully support the new program integrity efforts to defeat fraud in Minnesota's human services programs. However certain rushed changes in law won't prevent fraud. It would be a mistake to change Minnesota laws based solely on hastily drawn conclusions from a redacted Optum report, itself a massive for-profit health care corporation with conflicts of interest in Medicaid, and its own track record of Department of Justice investigations for Medicare billing fraud and antitrust violations.[1]

We urge you to reject the proposed billing limits for EIDBI services that are included in HF4338 at page 211.9-20. These billing limits were not the product of family or providers' input and will have the unintended result of cutting off services to the most challenging cases, and especially curtailing services to rural families. These caps override clinical judgment, use inconsistent terminology, and risk turning medically necessary care into a more costly one-size-fits-all model. In the place of these limits, we urge you to authorize a one-year study of the impact of the limits.

We urge the House to reject the Senate's language impacting EIDBI Observation and Direction ("O & D"), in order to allow this crucial service to be delivered by either QSP, Level I, or Level II providers under the clinical responsibility of the QSP. This is a key provision because the current workforce shortage prevents agencies from hiring sufficient QSPs to do the meaningful work that it entails. Current statute includes the Level II professionals for the good reasons that have been established over the past decade. This will enable families to continue their current levels of medically necessary services.

Fortunately, drafters of the EIDBI statute in 2013 paid careful attention to the families and provider task forces and work groups and the subsequent work groups over the next decade. They recognized the significant workforce shortage and so incorporated the generally accepted national standard for the tiered model of ABA, as published by the Behavior Analyst Certification Board and the Council of Autism Service Providers. The tiered model was explicitly

[1] *See, e.g.*, Snowbeck, Christoper, Report: DOJ investigating Medicare Advantage billing at UnitedHealth (Feb. 21, 2025), *available at:* https://www.startribune.com/report-doj-investigating-medicare-advantage-billing-practices-at-unitedhealth-group/601226396

designed to address the workforce shortage, by extending the supervisory reach of the QSP to the Level I and II providers, while still requiring that the QSP takes professional responsibility for appropriately delegating services, as they are licensed to do by the Minnesota Board of Psychology. Hence the Observation and Direction requirement still allows providers to fully extend medically necessary supervision through the additional services of Level I and II providers. In addition, the national standards call for the flexible prescription of the optimum hours based upon the clinical judgement of the QSP, as opposed to a third party that has no direct knowledge of the circumstances of the individual child.

If the QSP's clinical judgement and the workforce shortage were not taken into account, the resulting loss of access to EIDBI services would have devastating health effects for children with Autism.

We also express serious concerns over the 30-day financial capacity and surety bond language which imposes an additional cost on the providers (Art. 1, Section 12). Amendments in the 1st Engrossment improved the original proposal but still require $50,000 to $100,000 surety bonds and 30-days minimum financial capacity to operate and repay improper payments. This ties up capital, creates barriers for small, mid-sized, rural, and new providers, and adds cost without clear evidence it improves program integrity. We understand that this would amount to a requirement for high-risk providers to obtain millions of dollars in operational reserves. Note that these providers have already had one payment cycle withheld by DHS in 2026, and also now face high licensing fees to be paid to DHS for the revalidation and the provisional licenses this year.

This financial requirement creates a risk that small, nonprofit providers will be forced to sell their organizations to larger for-profit and private equity-financed organizations. This seems to go in the opposite ownership direction of what we have heard from lawmakers this year. Therefore, we request that you reevaluate and scale back surety bond and financial capacity requirements to protect provider participation and access to care.

When ethical providers have the financial ability to deliver effective services, the families will be less susceptible to being recruited by fraudulent providers.

Sincerely,

Eric V. Larsson, PhD, LP, LBA, BCBA-D, QSP

Chair, Autism Treatment Association of Minnesota

I am writing to ask you to support an amendment to include HF4288 into HF4338 the House Human Services and Finance omnibus bill that would move Family Residential Services (FRS) providers off of the current flat-rate reimbursement system and back to the Disability Wavier Rate System (DWRS).

My name is Karly Manion. I have been providing Family Residential services, Adult Foster Care, in my Woodbury home for 18 years and support 2 adults with disabilities. Before that I supervised a 6 bed Corporate Residential Setting home for 7 years. I am the primary care giver. I am the asleep overnight staff, the 24/7 on call staff, the morning staff, the evening staff and the weekend staff. I am the medical coordinator and provide transportation that is not compensated under the flat rate tiered model but legally required. If I want time off work, I need to hire someone to replace me at additional cost and leave my home.

We are not "family help", we are a licensed business operating with administrative, accounting, payroll, retirement, insurance, training and overhead costs.

When a client is absent from the home for a full 24-hour period—I am not allowed to bill for services. Currently for one client its 5 days and the other client its zero days a year. If a billing limit of 351 days is implemented, it would require me to work 14 days without compensation on top of the rate reduction.

The new tiered flat daily rate doesn't account for complex needs or differences between day program attendees and those at home. Both of the people I support have a case mix letter: B and fall into tier 3. (see chart below) They would not qualify for the additional funding in the Senate Omnibus bill. Under this model, my funding would drop by 10% for one person and 25.5% for another—significant cuts that severely underfund my services.

I have considered:

- Closing my doors, which would force the individuals I support out of the least-restrictive, home-based settings and separate them.

Family Residential Services are not institutions — they are homes. My home is a small, community-based setting that allows the adults with disabilities I support to live with dignity, choice, and belonging.

Moving FRS providers to the flat rate tiered model does not save the state money. It will force FRS homes to close displacing individuals with disabilities forcing them to move from a stable environment. They will end up in hospitals, long term care facilities, nursing homes, mental health crisis centers or Community Residential Settings (CRS). These settings will cost the state more.

I respectfully ask that you support this amendment to move FRS providers back to the disability wavier rate system (DWRS) and help protect the individuals and providers who make community-based care possible in Minnesota.

Thank you for your consideration.

Karly Manion
Family Adult Foster Care Provider
11460 Dale Road
Woodbury, MN 55129
Karly.manion@gmail.com
651-444-9131

Case Mix	**Support Tier**	**FRS Rate (per day)**	**Life Sharing Rate (per day)**
A	1	$194.83	$214.31
D	2	$234.94	$258.43
B, C, E, F	3	$254.06	$279.47
G	4	$306.07	$336.68
I	5	$306.07	$336.68
H, J, K	6	$383.33	$421.66

Re: HF4466 Health Finance Bill

April 28, 2026

Dear Chair Torkelson, Chair Frazier and Members of the House Ways and Means Committee:

ISAIAH is a statewide organization of congregations and other community-based constituencies working towards an economy where everyone can thrive and a democracy that honors every person's dignity. We are writing to share our concerns with HF4466.

Federal H.R. 1 (H.R. 1) represents an assault on American values—slashing resources and supports for thriving families and communities in order to fund tax breaks for billionaires and the expansion of armed paramilitary forces in our streets. The consequences for Minnesotans are devastating. At the same time, we understand that the federal framework includes significant additional budget punishments for states that do not conform.

We appreciate the many comments throughout the legislative session from legislators across the political spectrum acknowledging that conforming to these federal changes—particularly regarding Medicaid and SNAP eligibility—is painful, and that these decisions are being made under duress. We also recognize that federal guidance on implementation has been slow, insufficient, and continues to evolve through official channels and ongoing conversations with Centers for Medicare & Medicaid Services.

Given this uncertainty, we urge you to continue working on HF4466 beyond the floor process and through conference committee to protect eligibility and access to healthcare and essential supports as much as possible while avoiding more severe federal penalties for nonconformity. In particular, we ask that you:

- **Embed contingency wherever possible**, so that the policy changes you do make are only triggered when and if they are required by federal law. This will prevent unnecessary harm if federal requirements shift or are delayed.

- **Minimize and streamline administrative burden** on counties and eligibility workers. This includes both critical IT investments and, just as importantly, clear and careful decisions regarding exemptions, exceptions, and exclusions from work requirements. These choices will be essential for maintaining coverage for eligible Minnesotans and avoiding additional strain on already overwhelmed eligibility systems that are at very real risk of collapse as a result of HR1.

- **Preserve the current three-month retroactive coverage period**. We strongly oppose the premature shortening of retroactive coverage timelines, (Article 3, Section 7) especially when three months of retroactive coverage is already built into the state

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forecast. Reducing this coverage is effectively a direct cut to hospitals and providers, as retroactive eligibility is most often triggered when individuals present with acute needs.

Minnesota's health and human services infrastructure is already under extraordinary strain. The choices made in HF4466 will determine whether we preserve access to care and basic supports for those who qualify, or whether administrative complexity and coverage losses deepen the financial crisis.

We urge you to proceed with caution, clarity, and a commitment to protecting Minnesotans to the greatest extent possible under these federal constraints.

Thank you, as always, for your service to the people of Minnesota and for your consideration of our comments.

Sincerely,

Lars Negstad, Policy Director

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Dear Committee Members:

On behalf of the Disability Community we serve, thank you for your service and attention to our written letters of testimony today. I ask you to add an amendment to HF 4338 that includes HF 4288. This would reenact the full DWRS Framework Rate Methodology for Family Residential Services (FRS).
As FRS Providers, our business is serving and caring for real human beings, individuals from our MN communities with various complex medical, physical, cognitive, and serious & persistent mental health disabilities, not related to us, yet living as a family, in our personal home.
Legislative leaders please read, hear our collective pleas, and understand:

- *What it actually takes to support individuals living with Disabilities in Family Residential settings*
- *How policy decisions impact stability, staffing, and quality of life for individuals living with Disabilities*
- *Significant wage disparity between all proposed FRS Flat Tiered-Rates vs DWRS Framework Rate*

The problem: Many assessments place individuals in Level L, that rate is $254.06, or $10.59 per hour, below minimum wage in every region of the state. The House must add an amendment to HF 4338 that includes HF 4288 to return to the Disability Waiver Rates System (DWRS) Framework Rate Methodology for FRS.
The flat rate tiers do not cover the actual cost of providing care to individuals with high-acuity needs who require Waivers/ Intensive support services. When you calculate the hours required against the rate, providers are being paid less than minimum wage to do this work. Homes are closing as a result, and vulnerable adults are being displaced from the only stable environment many of them have known.

The cost to taxpayers: This is not a cost savings for the state. Displaced residents will be a homeless risk, end up in hospital beds at facilities like HCMC, or in Community Residential Settings, which cost roughly three times the rate FRS providers received under the original Disability Waiver Rate System. The Flat Rate appears to save money on paper, yet will shift far greater costs to other parts of the system.

HF 4288 offers a straightforward, targeted solution: it simply reenacts the framework rates that have successfully supported FRS under DWRS since 2014. This is not a new program or major spending increase — it is a common-sense solution to prevent a crisis already looming for hundreds of Minnesotans with Disabilities and the families and Direct Support Professionals who support them.

Our story: I submit my letter to you today, compelled by an encouraging statement Chair & Co-Author of SF 4310 Senator Hoffman made in Committee last month to "remember WHY I do what I do". Since 2014 from our little corner of the world in St. Cloud, I have experienced firsthand the life-changing impact of providing high-quality, person-centered residential supports and advocacy, for 19 women living in our home, at various times. They are Vulnerable Adults, who are under-represented and marginalized Minnesotans.

As FRS Providers, our "WHY" is also doing the work others consistently comment "I could NEVER do what you do!" and are unable/unwilling to do. The people I support live in my family home, not a facility. Our FRS has been able to prevent unnecessary institutionalization and hospitalizations of those ladies we've served over the decade. That stability matters!

The Flat Rate at all proposed rates is crushing honest FRS providers by defunding a program that provides critical housing stability, trauma-informed care, and intensive, individualized, supportive habilitation services to thousands of Disabled & Vulnerable Adults. I'm also concerned there is a serious disconnect between DHS, FRS, and our Legislators that cannot be explained to you in a 2 minute sound bite, yet MARSH representatives (and especially their Packet) address thoroughly and professionally. You cannot promise integration, independence, and person-centered care, then underfund the very services that make it possible.

Please ask yourself, "Who would continue doing the same amount of work including all the required responsibility, training, and compliance, pay significantly increased licensing fees to provide services, while compensated 30-70% LESS funding?" I cannot live off accolades.

This Flat Rate Tiered System was passed in 2023 to take effect on January 1, 2026, ultimately de-funding Minnesota's Vulnerable Adults living in FRS homes. FRS is considered an Intensive Service, not just a Housing Model. It is critical to ensure these vital services remain under the proven Disability Waiver Rate System (DWRS),like all the other groups that provide Waiver Services and compliance.
David Lubowitz,

Dear Honorable Co-Chairs Torkelson & Frazier, Vice Chairs Scott & Agbaje, and Ways and Means Committee Members:

On behalf of the Disability Community we serve, thank you for your service and attention to our written letters of testimony today **I ask you to add an amendment to HF 4338 that includes HF 4288: REENACT the full DWRS Framework Rate Methodology for Family Residential Services (FRS).**

As FRS Providers, our business is serving and caring for **REAL HUMAN BEINGS**, individuals from our MN communities with various **complex medical, physical, cognitive, and serious & persistent mental health disabilities, not related to us, yet living as a family, in our personal home.**

Legislative leaders please read, hear our collective pleas, and understand:

- *What it actually takes to support individuals living with Disabilities in Family Residential settings*
- *How policy decisions impact stability, staffing, and quality of life for individuals living with Disabilities*
- *Significant wage disparity between all proposed FRS Flat Tiered-Rates vs DWRS Framework Rate*

The problem: A20 is already in the Senate Omnibus. It provides ***selective*** rate increases for some MnChoices Assessment levels yet does not restore the framework rate. Many assessments place individuals in Level L, which A20 leaves at $254.06, or $10.59 per hour, **below minimum wage** in every region of the state. The Senate must amend A20 to do what SF 4310 does REENACT the full Disability Waiver Rates System (DWRS) Framework Rate Methodology for FRS.

The Flat Rate Tiers do NOT cover the actual cost of providing care to individuals with high-acuity needs who require Waivers/ Intensive support services. When you calculate the hours required against the rate, providers are being **paid less than minimum wage** to do this work. Homes are closing as a result, and vulnerable adults are being displaced from the only stable environment many of them have known.

The cost to taxpayers: This is NOT a cost savings for the state. Displaced residents will be a homeless risk, end up in hospital beds at facilities like HCMC, or in Community Residential Settings, which cost roughly three times the rate FRS providers received under the original Disability Waiver Rate System. The Flat Rate appears to save money on paper, yet will shift far greater costs to other parts of the system.

HF 4288 offers a straightforward, targeted solution: it simply reenacts the framework rates that have successfully supported FRS under DWRS since 2014. This is not a new program or major spending increase — it is a common-sense solution to prevent a crisis already looming for hundreds of Minnesotans with Disabilities and the families and Direct Support Professionals who support them.

Our story: I submit my letter to you today, compelled by an encouraging statement Human Services Chair & Co-Author of HF4288 Senator Hoffman made in Committee last month to "remember WHY I do what I do". Since 2014 from our little corner of the world in St. Cloud, I have experienced firsthand the life-changing impact of providing high-quality, person-centered residential supports and advocacy, for 19 women living in our home, at various times. They are Vulnerable Adults, who are under-represented and marginalized Minnesotans.

As FRS Providers, our "WHY" is also doing the work others consistently comment "**I could NEVER do what you do!**" and are unable/unwilling to do. The people I support live in my family home, not a facility. Our FRS has been able to prevent unnecessary institutionalization and hospitalizations of those ladies we've served over the decade. That stability matters!

The Flat Rate at all proposed rates is crushing honest FRS providers by defunding a program that provides critical housing stability, trauma-informed care, and intensive, individualized, supportive habilitation services to thousands of Disabled & Vulnerable Adults. I'm also concerned there is a serious disconnect between DHS, FRS, and our Legislators that cannot be explained to you in a 2 minute sound bite, yet MARSH representatives (and especially their Senate Packet) address thoroughly and professionally. You cannot promise integration, independence, and person-centered care, then underfund the very services that make it possible.

Please ask yourself, "Who would continue doing the same amount of work including all the required responsibility, training, and compliance, pay significantly increased licensing fees to provide services, while **compensated 30-70% LESS funding**?" I cannot live off accolades.

This Flat Rate Tiered System was passed in 2023 to take effect on January 1, 2026, ultimately de-funding Minnesota's Vulnerable Adults living in FRS homes. FRS is considered an Intensive Service, not just a Housing Model. It is critical to ensure these vital services remain under the proven Disability Waiver Rate System (DWRS),like all the other groups that provide Waiver Services and compliance.

Eliminating DWRS as a methodology of payment for those we serve means **reducing THEIR services, quality of life, opportunities to access the community (integration, activities, programming) and choice of housing.These dollars are NOT my take home pay.** This is funding built into Programming Costs. Two specific examples of those de-funded person-centered categories, based on 2026 DWRS annual values include:Transportation for Standard vehicle $2184.16/ Adapted Vehicle With Lift $3,900.26 AND Client Programming and Supports $2832.90. Categories cover ANNUAL costs to provide participants access to the community, supplies and equipment not available through MA state plan or other waiver services; Participation costs for staff; Reinforcers as defined in the participant's support plan, pertaining to service outcomes (goals).

Many times I've heard this Committee value and reference "Continuity of Care". Minnesota's FRS providers, who deliver 24/7 care to individuals with significant disabilities in family settings, are struggling from unsustainable Flat Rates that ignore medical and mental health complexity, real time behavioral challenges, aging needs, and individualized staffing requirements. **HF 4338 that includes HF 4288 MARSH Framework Reenactment** returns Framework Rates and Rate Exceptions that we can attest make true person-centered "Continuity of Care" possible.

The personal impact to our FRS: 2026 Flat Rates have created a 48% reduction to our program's funding, to do the same work with same compliance requirements, while paying increased licensing and other fees. I have already had to dismiss 2 Part-Time employees, who were the only Supplemental Supports that provided my husband & I limited support for needed time off, emergencies, our own medical/ self-care needs. Cutting DWRS rates by implementing the Flat Rate is already creating chaos and disrupting "Continuity of Care" for many Vulnerable Adult Minnesotans. Providers across the state, like me will be forced to reduce services, dismiss Supplemental Support staff, or close entirely. The result will be thousands of displaced persons, disrupted lives, destabilization with increased hospitalizations, higher state costs for more expensive corporate and institutional placements, and families left without options.

Thank you Committee Members for your valuable work at the Legislature, for leadership on Fiscal issues, and for protecting Vulnerable Minnesotans. I sincerely appreciate your support of our individual and collective effort to communicate this important message to you, that our voices would be heard by those elected to represent us.

Please Act Now! I respectfully urge you to **amendment HF 4338 that includes HF 4288**. This Bill **REENACTS the full DWRS Framework Rate Methodology for Family Residential Services (FRS)** in 2027, ensuring these vital services remain under the proven Disability Waiver Rate System (DWRS), like all the other groups that provide Waiver Services and compliance, instead of creating another "DHS System failure" de-funding FRS with the Flat tiered-rate.

Help protect the individuals and FRS providers who make a FAMILY and HOME community-based care possible in Minnesota. Thank you for your time and consideration.

Tami Lubowitz,

Tami Lubowitz
ARRM Member in support of MARSH FRS Framework Reenactment
The Way Home, LLC
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