

April 14, 2025

Dear Chairs Noor and Schomacker:

On behalf of the Minnesota Department of Human Services, thank you for your work to improve the human services system. The Governor's top priorities for this session are federal compliance and improving program integrity. The House Human Services supplemental budget bill (HF 4338) incorporates many of our program integrity supplemental budget recommendations and other key provisions that ensure federal compliance and overall system transformation:

- Enhancing public safety, improving outcomes for people, and conforming with federal requirements to **provide adults and youth exiting correctional settings with pre- and post-release case management services.**
- **Funding to comply with federal home and community-based services access rule requirements**, which will increase transparency and accountability, standardize data reporting, and promote more beneficiary engagement.
- Aligning with federal regulations that **prohibit Federal Bureau of Investigation (FBI) background studies for household members of adult day service and adult foster care providers.**
- **Studying waiver case management reimbursement rates and core functions** to improve quality of services and workforce retention.
- **Accelerating implementation of recovery residence standards and access to supportive housing** to ensure strong program controls that lead to positive outcomes for people in recovery.
- Fully **implementing Mental Health Uniform Service Standards (USS)**, which transitions unlicensed services to a licensing framework. This shift increases program oversight for Children's Therapeutic Services and Supports (CTSS), Adult Rehabilitation Mental Health Services (ARMHS), Crisis Response Services, and Certified Community Behavioral Health Clinics (CCBHCs).
- **Establishing billing thresholds for Disability, Older Adult, and Behavioral Health services.** This change will allow DHS to better track service utilization while ensuring access for people whose support needs exceed the thresholds.
- **Expanding the use of Electronic Visit Verification (EVV)** to more high-risk service types.
- **Funding for prepayment review, post-payment review**, and requiring managed care organizations to conduct prepayment review and publish information on program integrity actions and outcomes.
- **Codifying a definition of fraud in Medicaid statute** to clarify DHS's authority, as recommended by the Office of Legislative Auditor.
- **Requiring DHS to consult with counties and Tribal Nations to recommend strategies that transform the human services system**, ensuring transparent, accessible, accountable, and effective service delivery.
- **Establishing a team at the state-level to support counties on addressing MnCHOICES assessment backlogs.**

As your bill advances through the legislative process, we hope to continue discussions about enhancing safety standards for DHS Licensing staff who face threatening and violent interactions in the workplace. In addition, DHS hopes to continue discussions on reforms to strengthen oversight of Integrated Community Supports, ensuring billed services align with services delivered.

Our team will continue to analyze the bill and provide feedback and technical assistance. Thank you again for your leadership and collaboration.

Sincerely,

John Connolly  
Deputy Commissioner & Medicaid Director  
Minnesota Department of Human Services

April 14, 2026

Chair Noor, Chair Schomacker, and Members of the Human Services Committee:

On behalf of ARRM and our over 200 disability residential waiver service providers, thank you for the opportunity to provide comments on HF 4338, the Human Services Omnibus Finance Program Integrity bill.

First, we want to thank the committee for the thoughtful discussion and collaboration this session around proposals that will strengthen services provided to people with disabilities and ensure strong program integrity standards are in place.

We would also like to thank the committee for not moving forward with the Governor's proposal to eliminate remote supports in provider-controlled settings. Minnesota has been a leader in the use of remote support and assistive technology for people with disabilities. Beginning in 2009, assistive technology has played an important role in the services that people can access, has helped promote independence, and has been a helpful tool in addressing our workforce shortage. Eliminating this service option would have set us back.

We are also grateful to the committee for not including any of the provisions included in the Governor's budget proposal that would have resulted in significant rate cuts for providers, including capping billable days at 351 for residential service providers and capping inflationary adjustments at 2% annually. At a time when providers continue to grapple with workforce shortages due to low wages and increasing costs in all areas of service delivery, any additional funding cuts would be devastating.

As the committee continues to consider the proposals included in HF 4338, ARRM would like to highlight concerns and questions with the following proposals:

- **Electronic Visit Verification (Article 6, Section 6):** ARRM supports strong program integrity measures and believes that Electronic Visit Verification is an important tool in ensuring services are being provided. We question the applicability of the tool for daily rate services that are provided in a shared fashion, such as Community Residential Services and Family Residential Services. We want to thank the committee for not including these services on the list of EVV required services, but we have concerns with the language included on line 201.15 that gives authority to the Commissioner to apply EVV to any service they determine. We strongly believe that any changes should be considered carefully through the legislative process rather than independently through the agency.
- **Billing Limits (Article 6, Section 18):** ARRM opposes the language contained in Article 6, Section 18, (b) (7), which establishes one-to-one staffing limits for individuals living in



a Community Residential Setting (CRS). As drafted, the Commissioner would have the authority, outside of the legislature, to establish the billing limits. This proposal would drastically change how services are currently provided in a CRS and was established without collaboration with the provider community. Initially, we have the following questions:

- How does this impact individuals who live in a one-person CRS and have 24-hour one-to-one staffing? If they are not assessed at the appropriate acuity level that allows for that level of one-to-one staffing, will they still be able to live in that home?
  - How are the limits going to be determined by the Commissioner? What data or information is being proposed to make the decisions on the appropriate level of one-to-one staffing?
  - How easy is it to change the amount of one-to-one staffing if acuity changes? Will an individual need to go through the assessment process again?
  - Individuals may need 2 to 1 or even 3 to 1 staffing. Will levels be set to allow for up to 48 or 72 hours of one-to-one staffing per day?
  - How will the one-to-one staffing account for an open bed, and the impact that will have on the shared staffing an individual accesses?
- **Billing Limits (Article 6, Section 18):** ARRM is grateful for this committee's consideration and inclusion of ARRM's proposal to change the 6-hour daily limit for IHST to a monthly limit and remove the 3-hour consecutive language in the Human Services Omnibus Policy Bill (HF 729). Article 6, Section 18 (b)(9) contains the daily limit and 3-hour consecutive restriction, as the committee continues to work on this proposal, we would advocate for the monthly cap for IHST that is moving in the Omnibus Policy bill to be included in this language, providing individuals receiving support flexibility on a day-to-day basis.
  - **Documentation of Staffing, Auditing and Review (Article 6, Section 20):** ARRM supports strong program integrity standards in all services, including Community Residential Services. Article 6, Section 20 implements new documentation of staffing requirements, requiring providers to maintain documentation of direct staffing hours provided to each person receiving services. The proposal also allows the Commissioner to make recommendations on future rates based on the staffing documentation provided. When setting a future rate, lead agencies use the assessment tool and the Disability Waiver Rate System framework tool to determine the appropriate rate for an individual. We would question whether using the previous year's staffing is an effective or appropriate way to determine a future rate for an individual. When setting rates, the individual's need should be at the forefront. We have concerns that this proposal could set up a situation where, due to short staffing in the previous year, the individual is not able to access a rate to meet their needs in the coming service year.
  - **Integrated Community Supports Reform Study (Article 6, Section 26):** We would like to thank the committee for not including language that would change Integrated Community Supports (ICS) to a 15-minute unit service and instead, establishing language that would require the Commissioner to review the service and make recommendations for future changes. We agree that changes need to be made in how

the service is administered, but want to make sure that changes are made in a thoughtful way that considers the acuity needs of everyone accessing the service.

Again, we would like to thank the committee for their thoughtful and balanced approach to addressing program integrity with the individuals served and their providers in mind. As this proposal continues, we look forward to continuing that collaboration with the legislature to ensure that the operational reality of providing services aligns with the need to strengthen our programs.

Sara Grafstrom  
Senior Director of State and Federal Policy, ARRM



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**An association of resources and advocacy for children, youth and families**  
[www.aspiremn.org](http://www.aspiremn.org)

April 14, 2026

Dear Co-Chair Noor, C-Chair Schomacker and Members of the Human Services Finance and Policy Committee,

AspireMN is a statewide association of children and family serving organizations with delivery of care in children's mental health, child welfare, and a variety of service models oriented to provide early intervention for families, meet critical needs and promote family preservation.

We appreciate the thoughtful work of this committee in seeking to enhance integrity of Medicaid systems and preserve our ability to delivery quality care to enrollees. AspireMN members are in complete alignment with the interest of this committee to take prudent measures to protect the asset that Medicaid represents for all of the children, families and neighbors supported by Medicaid statewide. This is complex work and we believe there is more work yet to be done and remain glad to continue to engage with DHS, lawmakers and all stakeholders until we arrive at an approach that is good for Minnesota Medicaid and all who contribute to delivering care.

Challenges include:

- Proposed provider enrollment surety bond amounts are incongruent with financials for children's mental health providers. Delivering quality care with financial integrity is the status quo for our providers, and, due to inadequate reimbursement rates and a disproportionate reliance on Medicaid for access to children's mental health care (members report Medicaid as the primary payor for 65% and above for clients served), holding 10% of overall receipts in the form of a surety bond is not realistic. We are glad to continue conversation on alternative measures to demonstrate sound financial management and sustainability.
- Uniform Service Standards is an incredibly important project and one we have been grateful to partner with DHS on since 2017. We are glad to see language and investment moving forward to support service licensure and are in complete alignment with the goals as laid out in this section. The proposed licensing fees would be a dramatic increase in cost and pose significant challenge. We appreciate the openness of DHS to be in dialogue on these challenges and look forward to continued review.

This committee has been attentive to seeking solutions for children experiencing boarding in hospitals, detention and with counties. This proposal includes two important provisions that respond to this continued crisis for children and families including:

**AspireMN improves the lives of children, youth and families served by member organizations through support for quality service delivery, leadership development and policy advocacy.**

- Inclusion of updated language for Youth ACT services will help assure this valuable care can more effectively reach and support children with acute mental health needs while also equipping their families as the child accesses treatment.
- Adding Carceral Case Management services for children who are transitioning from juvenile detention as these young people experiences some of the greatest vulnerabilities and can benefit significantly from this support as they transition to community life.

Once again, we thank you for the thoughtful leadership of this committee on behalf of Minnesota's children, youth and families and look forward to continued dialogue.

Warm regards,

A handwritten signature in cursive script that reads "Kirsten Anderson".

Kirsten Anderson  
Executive Director

**AspireMN improves the lives of children, youth and families served by member organizations through support for quality service delivery, leadership development and policy advocacy.**

1919 University Avenue W. #450, St. Paul, Minnesota 55104



# ATAM

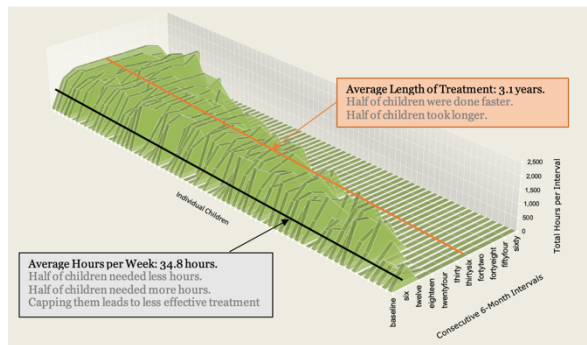
AUTISM TREATMENT ASSOCIATION  
OF MINNESOTA

## Imposing EIDBI Billing Limits on trusted providers does not prevent fraud. Delete HF4338-DE1 amendment, article 6 section 15.

The children who cost the most to Medical Assistance are the ones that don't get the intensive when they needed it. Any cap on treatment hours always hurts them the most.

While paradoxically a one-size-fits-all program leads to over-billing for the children who don't need full intensity, because it does nothing to stop fraud. It only incentivizes fraud.

A more effective way to prevent fraud is to right-size the funding by fully paying for accountability. Cover the full costs of individualized assessment, treatment planning, and supervision, instead of cutting corners. It is easier to spot fraud when high quality care is possible.

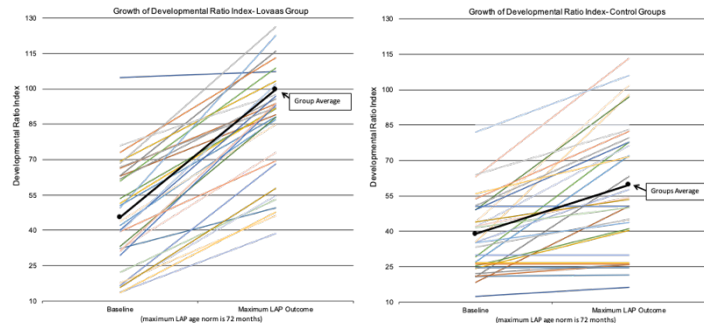


### Individualized treatment is the most effective.

Each green row is a different child, showing their total treatment hours every six months. Because the average intensity could vary, each child's length of treatment was optimized.

### Intensive treatment is more effective.

Each line is a different individual child, showing their increases in IQs. On the left are the children in the uncapped intensive treatment group, who gained an average of 53 IQ points. On the right are the children who received less hours of treatment, who gained an average of only 20 points.



For 30 years, we've seen the payers hear about the average number of hours, and turn it into a cap on intensity. If you are familiar with the disaster that led to the Jensen settlement, it came from a lack of intensive assessment, treatment planning, and supervision.

### It is more expensive to either deliver too few hours, or too much hours of treatment.

### Manage Treatment Separately for Each Individual Child and Spot Fraud More Quickly.

*We're helping people with autism.*

Contact: Daniel L. Pollock – [dpollock@locklaw.com](mailto:dpollock@locklaw.com) – 612-889-4649 – [atamn.org](http://atamn.org)

**ATAM, The Autism Treatment Association of Minnesota:** Action Behavior Centers, Anod Inc., Autism Matters, Behavior Frontiers, Behavioral Dimensions, Bridge Autism Clinic, Caravel Autism Health, Foundations Autism Center, Holland Center, JtC AUSM, Kids Discovery Center, Lazarus Project, Lovaas Institute Midwest, Minnesota Autism Center Midwest, Minnesota Behavioral Specialists, Momentum Behavior Services, Nolan's Place, Northway Academy, Partners in Excellence, Solutions Behavioral Healthcare Professionals, The READY Clinic / SWWC, The Rochester Center for Children, and Village Wellness Center





April 15, 2026

To: Chair Noor and Chair Schomacker  
CC: Members of the House Human Services Committee  
RE: HF4338 - House omnibus budget bill

Dear Chair Noor and Chair Schomacker:

We appreciate the opportunity to provide feedback on the [House's DE](#) to HF4338.

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 appreciate and recognize the committee's desire to strengthen program integrity measures and internal controls for our state's Medicaid program. At the same time, we urge careful consideration of new regulations which may not align with how services are delivered or create unnecessary administrative burdens. We are committed to working with legislators to strengthen program integrity through oversight approaches that align with how services are actually delivered and do not create obstacles to the delivery of essential services for Minnesotans.

Areas we are seeking further refinement as this moves forward:

- **Article 6, sec. 7:** 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. 16:** We encourage the committee to consider inclusion of language establishing an appeal process for providers to enroll in Minnesota's Medicaid program in the event of a statewide or regional moratorium. This would better preserve accessibility of services based on an identified need by geography, specialty population, or related continuity of care considerations. A similar process was effectuated during last year's special session regarding licensing moratoriums (see [Chapter 9, Article 10, sec. 1](#)).
- **Article 6, sec. 20 - 22:** 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.

- We also hope that the committee will take consideration of necessary investments and technology integration for lead agencies to improve timely processing and approval of Medicaid applications. Providers and families are waiting an average of 100 days or longer and we cannot delay making these necessary upgrades and integrations.

We appreciate that these are significant policy concepts to put into legislative language and therefore require substantial work to develop. We can't help but remain disappointed that the process thus far has not been one of collaboration where impacted providers, lawmakers and regulators could work together to strengthen program integrity and ensure operational and regulatory feasibility. We all share goals of providing quality services to Minnesotans across the state and being careful stewards of state resources; the result is stronger when it is developed together. We look forward to conducting this work now as we continue to assess the language and its impacts.

Respectfully,

Erin Huppert  
VP Advocacy, LeadingAge MN  
LTC Imperative

Kyle Berndt  
Sr. Director Advocacy, Care Providers MN  
LTC Imperative



## Minnesota Association of Community Mental Health Programs

Representative Joe Schomacker, Co-Chair  
Representative Mohamud Noor, Co-Chair  
Human Services Finance & Policy Committee  
MN House of Representatives  
April 15, 2026

Dear Co-Chairs Schomacker and Noor and Committee Members

On behalf of the Minnesota Association of Community Mental Health Programs (MACMHP) I am sending this letter in response to House File 4338 – Human Services Omnibus Finance bill. The Minnesota Association of Community Mental Health Programs (MACMHP) is the state's leading association for Community Mental Health Programs, representing 36 community-based mental health programs and CCBHCs across the state. MACMHP's member agencies all provide a spectrum of mental health and substance use disorder services to our communities from the same organization. As essential community providers, MACMHP member clinics serve some our most medically complex individuals with many social and economic challenges.

Specifically, MACMHP is sending this written testimony on Article 5 - Uniform Service Standards. MACMHP thanks the committee and the Department for moving these proposals forward. We appreciate you continuing the work our provider associations and memberships started and advocated for over the past five years. You passed legislation requiring adult rehabilitative mental health services (ARMHS), children's therapeutic services and supports (CTSS), Mobile Crisis and Certified community behavioral health clinics (CCBHC) to move to licensure. We appreciate yours and the Department's work to bring the implementation language to carry that out here.

With that, we have some concerns with some of the current language in Article X, which we shared with the Department, outlined below:

- Proposed Licensing fee amounts and structure of applying them to each satellite site
- Proposed use of a specifically named assessment tool in law, locking in a specific tool as opposed to leaving the ability to flex when the clinical standards evolve and change
- CCBHC language which would conflict with the federal criteria and standards keeping Minnesota's model aligned with the national fidelity

We already see positive updates in this language compared to earlier versions we reviewed, which we appreciate along with the intent to keep this work USS moving forward. We are in good conversations with the Department, and we are optimistic we can work out differences and concerns to come to a good place. Provider groups believe in the intent and goals of USS to streamline mental health regulations so our providers can focus on delivering high-quality care.

Thank you for your leadership and support.

Jin Lee Palen  
Executive Director

Testimony on HF 4338 pertaining to sections originally in the  
Governor's Budget Proposal

Honorable Chairs Schoemaker and Noor and members of the Committee,

My name is Lance Egley, Ph.D., L.A.D.C., C.A.D.C. III, L.I.C.S.W. I am Co-Chair of Northern Access Substance Use Disorder (SUD) network in Bemidji, MN and the MARRCH Lead for Systems Improvement and Paperwork Prevention. I can be reached at [lcegley@paulbunyan.net](mailto:lcegley@paulbunyan.net), p. (218) 751-9720, p. or txt (218) 308-3251. Today I testify on HF 4338 about parts of the bill originally in the Governor's Budget.

*The Governor's Budget Proposal contains change in Minnesota's Substance Use Disorder Treatment Systems. We comment on three provisions of that proposal from the perspective of the Department of Human Services Report ""**Recommendations for Minimizing Regulatory Paperwork and Improving Systems for Substance Use Disorder Programs**". This report was released early last Fall and is *getting far too little attention*, not only because of the merits of its recommendations deserve more attention, but because of the work of the Minnesota House of Representatives over three successive legislative sessions before the mandate to create it stuck. And because of the more than a year of collaboration between DHS, scores of providers statewide, and two national consulting firms: NIATx and Advocates for Human Potential (AHP) that went into making it. Moreover it has recommendations that directly address some issues before the legislature today. [Page numbers listed are from this DHS report.]*

#### PMAPs and Systems Simplification

*The Governor's budget as represented in SF 5042 Article 6, proposes that MCO's/ PMAPS transition MA to a single Administrative Service Organization (ASO) model. The relevant principle from the DHS report is to make requirements of payers for providers to receive compensation less complex and much more consistent across payers. P. 18 The DHS report describes the need this way: "Address the complex multi-payer environment involving Medical Assistance, Behavioral Health Fund, 8 Prepaid Medical Assistance Programs (PMAPS), 87 counties, 11 Tribal Nations, and private insurers." P. 5 Each of these payers has their own, often different, requirements for enrollment of programs, client admissions pre-approval, client services records, length of stay, billing, and utilization management. Learning all these different systems is exhausting to providers and completing the different documents required is time-consuming and requires going over the same material repeatedly to capture all the relevant information required by a particular clients particular payer. The Executive Summary*

also explains the impact of this inconsistency. “ ... *this report identifies excessive documentation requirements as a primary contributor to burnout among behavioral health providers, particularly Licensed Alcohol and Drug Counselors (LADCs), significantly compromising their ability to deliver effective patient care.* ” The DHS report then goes on to use Minnesota Department of Health and DEED research to show that there is a shortage of LADC’s that is only going to continue growing according to projections of data collected by the two Departments. The largest reason for leaving SUD services is “burnout” and the difficulty of dealing with the vast diversity of rules was specifically given as a reason for leaving SUD provider services. *The bottom line is that the diverse requirements make it extremely difficult for both direct service counseling staff and for billers to keep in compliance with all the diverse requirements. The implication for the Governor’s budget is that eliminating the MCO (Managed Care Organization)/ PMAP (Prepaid Medical Assistance Plans) system would remove 8 degrees of freedom from the variation of rules that has developed. If this is not approved then legislation is needed to get PMAPs to be consistent with each other in what providers must do to qualify to be in network, which clients get which levels of care and criteria for how long care lasts, the types of information and detail required in client services records, the types and formats of information that must be presented for billing, and the scope and expectation of utilization review.* To illustrate that this will require legislation to accomplish, look at a recently billing situation with Blue Plus. Last year the Minnesota legislature passed a significant rate increase for low intensity residential treatment, knowing that these programs would be needed going forward and without these increases the programs would not survive long enough to be part of emerging plans. The legislation passed in June, 2025 and the rate was effective January 1, 2026 – over six months later. Blue Plus placed in its provider contracts that it had up to 90 days or the first of the year to implement computer changes that would make changed rates effective, unless prohibited by State or Federal law. Blue Plus implemented the changed rates a full two months after the first of the year. Blue Plus used this contract provision to disallow back billing resubmissions to January 1, 2026. (Other PMAPs allowed back-billing and accomplished

implementation at various dates.) Attempts to negotiate with Blue Plus on this matter failed and a request was made to the Department of Human Services to Intervene. Ultimately this was referred to the Department of Human Services Behavioral Health Administrative Team, who decided they did not have the ability to intervene, despite the fact that Minnesota statute clearly set the date for the new rates to be effective. Thus, without legislative action, *Blue Plus moved the effective date of the 3.1 rate increase to approximately 2 months after January 1, 2026 – but only for providers who are paid through Blue Plus!*

### *The Need for Consistency and Transparency as the Basis of System Integrity*

*The other element in the Governor's Budget Bill proposal to which the DHS report speaks is the funding of more staff members for Program Integrity and Oversight. The DHS report specifically recommends that the Licensing Division be more transparent and more consistent in its operations. P. 16 It also recommends that Licensing practice become less punitive and focus more on developing provider's ability to comply with Licensing rules. Without consistency and transparency from DHS and Licensing providers don't know what is expected and cannot provide integrity about meeting requirements that were not consistently expressed. At the end of the year plus of collaboration the Licensing Division asserted that it has solved all these problems. Evidence is that it has not. At the same time Licensing was claiming to have solved all these problems 85% of the MARRCH Public Policy Committee voted to support legislation to require specific steps to make Licensing more consistent. What this information demonstrates is that clearly the Licensing Division needs more work on transparency. Providers don't believe what it says. There is also some evidence that Licensing Division needs more work on consistency. Recently one Licensing Reviewer advised a provider to make their Policy and Procedure conform to future licensing rules that would require only in person, interactive training to be acceptable for CEU's and that there would be a statewide uniform Comprehensive Assessment. Clearly this was information not authorized for release or the Department would have announced it in a public forum. To require in person, interactive training for everything would conflict with legislated requirements for certain training to occur before client*

contact, which can only be practically accomplished with recorded trainings that are available on demand. The DHS report does recommend a common statewide assessment core, but with provider freedom to add elements. *The relevance to the Governor's budget is that bringing in a large number of new staff will cause greater inconsistency without extensive inter-rater reliability training and will be distrusted by providers without significant improvements in transparency and support of program improvement over punishment.* If lack of consistency leaves providers confused about what compliance requires and lack of transparency prevents providers from asking for clarity and consistency on requirements then no amount of enforcement can avoid integrity problems. Providers cannot meet expectations if they do not clearly understand what the expectations are.

Clear Procedure is the Basis for All Successful Technology Solutions

*The Governor's budget also calls for a large sum for technology upgrades. Certainly many Minnesota computer systems need upgrading. However it reminds one of a statement made during the creation of computer systems leading to MMIS. Computer technology cannot keep up with systems that are unnecessarily complicated. You cannot find an adequate computer solution until you have a clean, straight-forward process to computerize. Also garbage in- garbage out. You cannot get meaningful computer results if the people who supply the data cannot understand or cannot obtain the data that is wanted. Technological upgrade needs to follow, not precede, systems process improvement. The DHS report touches on the need for technology upgrade, even though technology people had little involvement in the process of building the report. But the rest of the report tells the story of need to improve the human process that lies behind the technology use.*

*This is a small portion of the important, relevant recommendations in the DHS report that currently are being overlooked. The report deserves an informational hearing to call attention to its importance and positive principles for improving services. Also to take a hard look at the implementation ideas before starting on insufficient implementation of the goals and which may, in a few cases, risk making things worse.*



April 15, 2026

Dear Chair Noor, Chair Schomacker, and Committee Members:

Thank you for the opportunity to share Lutheran Social Service of Minnesota's (LSS) comments on HF 4338, the Omnibus Human Services Program Integrity Budget Bill. LSS is a provider of essential services across all 87 counties with more than 2,500 employees who serve one in 63 Minnesotans every year. This includes innovative and person-centered home and community-based services for older adults and people with disabilities.

For 160 years, LSS has served Minnesotans by providing high-quality, comprehensive services that help people move toward greater self-sufficiency at every stage of life. We earn and build trust through fiscal responsibility, compliance, and strong internal controls and financial oversight. We amplify this by supporting policies that reinforce program integrity, improve service effectiveness, and – most importantly – advance outcomes that allow people to live full and abundant lives.

We appreciate the Legislature's commitment to prioritizing policy solutions that strengthen oversight of Minnesota's Medical Assistance programs; however, we write today requesting your careful consideration of proposals included in HF 4388 that could disrupt essential services for Minnesotans in need.

**We request caution as policymakers consider expanding electronic visit verification (EVV) (Article 6, Sections 6-12).** LSS supports strong program integrity safeguards; however, increasing the number of programs subject to EVV does not safeguard against fraud when verification currently relies heavily on manual corrections. The existing technology does not consistently perform as intended, especially in communities lacking reliable broadband access. This results in providers resorting to manual corrections to achieve accurate data, even though those corrections are not technically compliant. We respectfully request that EVV expansion proceed only once the existing technologies are proven to work as intended, the data is reliable, and the policy improves accountability without creating barriers to care.



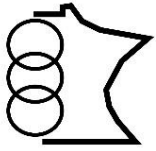
**We are concerned about the inclusion of language that appears to limit the use of remote supports (Article 6, Section 17).** LSS supports many individuals who utilize remote supports as a person-centered service. Our team members provide verbal cues, direct assistance, and deescalation support. This early intervention service supports their independence while mitigating unnecessary and expensive emergency calls or emergency department visits.

**The inclusion of billing limitations for Individualized Home Supports with Training (IHS-T) (Article 6, Section 18, lines 211.13-14) is also a concern.** This conflicts with policy moving forward in HF729, the Omnibus Human Services Policy Bill, modifying IHS-T limits by establishing a monthly cap on service hours, rather than a daily cap, and removing the 3-hour consecutive policy. These simple but impactful modifications would provide the flexibility needed to maintain service continuity for people who live in their own home. As a statewide provider, we have been especially concerned for those we support who have been assessed to require more hours of support including those who live in rural communities and those with a higher level of support needs. If IHS-T limitations are not addressed this year, it will disrupt access to the support and training required for people receiving services to fully participate in activities like community events, medical care, or household management.

Thank you, again, for this opportunity, and we look forward to ongoing collaboration on these issues. Please contact Erin Sutton, Senior Director of Public Policy, at [erin.sutton@lssmn.org](mailto:erin.sutton@lssmn.org) if we may provide further information.

Sincerely,

Patrick Thueson  
President  
Lutheran Social Service of Minnesota



**Office of  
Ombudsman for  
Long-Term Care**

April 15, 2026

Co-Chairs Noor and Schomacker and members of the Committee,

I am writing to you in support of Article 1, Section 21 of the DE for HF 4338. OOLTC appreciates the notification requirements when a service provider experiences a payment hold.

Notification of the appropriate ombudsperson offices is an essential and currently missing step in the payment hold process. OOLTC has received notification for some facilities with a payment hold, but not all. Clarifying a notification requirement in statute ensures people receiving services can be served by an advocate. OOLTC would appreciate being named in the bill specifically so we can partner with other ombudsperson offices, as we frequently do, to determine how to best support service recipients whose provider is experiencing a payment hold.

Furthermore, the notification of all people receiving services from a provider is important to ensure any person who may be impacted by a payment hold has clear information from a state agency, not the provider. Residents of an assisted living facility who are paying privately for care are impacted by a payment hold just as residents on a waiver are impacted. The facility as a whole loses revenue, and that could impact care for all residents served by that provider. Providing clear information to every resident or service recipient is a step to transparency and allows service recipients to make the best decisions for themselves.

OOLTC greatly appreciates the work of this Committee to ensure fraud, waste, and abuse is addressed while supporting the Minnesotans who rely on services every day. Thank you for your work supporting service recipients throughout the state.

Sincerely,

Parichay Rudina  
Legislative Specialist  
Office of Ombudsman for Long-Term Care

From: Aaron Jaccard, Certified Peer Support Specialist

Aaron Jaccard  
3845 Hiawatha Ave., APT 506  
Minneapolis, MN 55406-4454

Subject: DE amendment to HF4338 (the Program integrity finance package), specifically language around reducing pre-approved IRTS stays from 90 to 30 days.

Hello and thank you for taking the time to review my testimony. I am Aaron Jaccard, I live in Minneapolis where I work at an IRTS facility as a Certified Peer Support Specialist. Today, my path is focused on helping others who are struggling find hope and a way forward. But it was not always this way. Like many of the clients I now serve, I once felt completely alone, overwhelmed by anxiety and depression, and disconnected from the world around me. Years of battling my mental health left me feeling worn down, hopeless, and searching for a way out.

In a moment of desperation, I reached out to COPE. That call became a turning point, leading me to the Bill Kelly House IRTS facility.

For the first 10 days of my stay at the facility, I was simply exhausted and overwhelmed by the things I needed to accomplish to repair my life. It took an additional 5 days before I started opening up to people. And another 5 before I was able to get back on my medication and arrange for visits with my medical providers. That was 20 days of my 90 at this IRTS facility that was just spent learning how to feel human again.

Groups and one on one counseling helped me create a plan for my future. Getting the necessary forms filled out for government aid, resolving a legal matter, and most important figuring out what will happen after I leave the facility Housing is a huge challenge facing Minnesota, and one that takes weeks or months to navigate. This is a story that is repeated in my work at the IRTS facility. I see people everyday on this same journey. And it is a journey. A profound and important one. One that can't be squeezed into 30 days. Clients are at these facilities for 90 days. This is not an arbitrary number. It's a realistic expectation of the time it takes people to stand back up after falling so far.

Today, I stand on the other side of that experience as an employee at the very place that once welcomed me when I needed it most. That transformation didn't happen overnight. It came from showing up every day, doing the work, and making a conscious decision to build a better future for myself.

Bill Kelly House gave me more than treatment—it gave me the opportunity to truly change. If I had been rushed out the door after 30 days, I don't know that I would be where I am today. Having the time to dig deeper, to struggle, to grow, and to rebuild piece by piece is what made lasting change possible.

Now, I have the privilege of being part of that same process for others—offering the same patience, understanding, and belief that was once given to me.

A stay of only 30 days at an IRTS facility would end up being nothing more than a place to sleep for a month. Trying to accomplish all the things that need to be done in that short period of time is unrealistic and unkind. Housing alone takes many weeks. Getting back on meds and a proper routine takes weeks. Learning to be responsible for myself and my future took 90 days. No more and no less. It takes time.

Thank you for your attention.

Sincerely,

Aaron Jaccard

April 15, 2026

Dear Co-Chairs Schomacker and Noor,

Thank you for accepting these comments on the program integrity provisions in HF 4338.

As background, 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 that would be impacted by the changes in the proposed omnibus package.

In the past year, we served children, adults, and families in each of the districts of the members on the Human Services Finance and Policy committee.

We want to thank the committee in particular for these provisions:

- **Disability case management working group** (pages 217 to 220) -- Thank you to Rep. Fischer and other committee members 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.
- **ICS study** (page 220) -- Thank you for the committee's work this session to strengthen and improve Integrated Community Supports. We operate 5 community apartment settings for about 60 total individuals in the Twin Cities metro. ICS plays an important role in ensuring people with disabilities have meaningful opportunities to live in the community, and it is critical that this program continues to be supported and preserved as a viable option within the continuum of community living.
- **Uniform Service Standards** (pages 129 to 189) -- Thank you for allowing this proposal to move forward. Our CCBHC program 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. We also appreciate that the Department continues to work with provider groups to clarify some additional details in this large and important proposal.

We would also appreciate the committee keeping these concerns and suggestions in mind as additional work on the omnibus package continues this session:

- **EIDBI billing limits** (page 209) -- Fraser is the largest and oldest autism provider in the state. EIDBI has received multiple well-intended statute changes the past several sessions, as well as well-intended policy clarifications from the Department in between sessions. We are growing increasingly uncomfortable that these changes are creating confusion and unintended impacts that are quickly compounding. Our preference is that the EIDBI billing caps and other 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.
- **Electronic visit verification expansion** (pages 199 to 207) -- We appreciate that this proposal continues to be refined. Even with the option of a state-provided EVV system, we are concerned with the implementation timelines. Our early experience with EVV for a few of our programs is that it is very complex to operationalize.

Thank you again for the committee's efforts to improve our state's Medicaid services.

Sincerely,

Lucas Kunach  
Director of Business Development  
612-798-8303



On behalf of our organizations, we write to outline our thoughts on HF 4338 (Noor/Schomacker), the House omnibus human services supplemental budget proposal.

#### Transforming human services

Transformation of our human services delivery system is a key element of HF 4338 and counties are committed partners in this conversation. We support comprehensive study of the roles and responsibilities of counties, tribes and the state, and we welcome a robust working group to examine our system – provided that direction to the working group does not presuppose conclusions. **[Article 7, Section 12]**

#### Continuity of care

Counties appreciate the recognition of the state-county partnership when individuals are affected by disruptions in our provider community, no matter what the cause. In reviewing the language of this proposal, we would like more clarity in Lines 33.13-33.17 that describe lead agency duties. Unfortunately, when our residents are affected by provider disruption, it is incredibly difficult to find alternative placements. While counties may do their best to find a provider of choice, the reality is that the provider shortage is real. Counties would like to work with you to understand the process and financial impacts of this proposal. **[Article 1, Sections 21-23]**

We appreciate the direction to the Department of Human Services to assist counties in conducting long-term care assessments using certified assessors. This could provide the crucial support that counties have been asking for to address current backlogs. We look forward to partnering with DHS to determine the appropriate conditions in which these assessors are deployed. Counties have been working with the DHS to address current backlogs and stand ready to participate in another work group to discuss ongoing challenges and the potential redesign of MnCHOICES. **[Article 6, Sections 13, 27]**

#### Contracted case management

Counties use contracted waiver case management in a variety of ways – to fill staffing needs, provide more efficient service delivery and provide culturally appropriate services. This looks different in every one of Minnesota’s 87 counties. Counties appreciate this proposal’s focus on a robust study that examines current uses of contracted case management, evaluates our payment rates, explores appropriate guardrails, and discusses the proper role of counties. **[Article 6, Sections 24-25]**

#### Long-term services and supports

We appreciate the inclusion of several items that counties and others have been discussing as part of our work to find savings in our Long-Term Services and Supports (LTSS) area in advance of proposed significant cost shifts. As you consider these reforms, we strongly urge the Legislature to include language so that any savings are attributed to the cost shift target.

- **Article 6, Section 23**, would direct DHS to conduct a market rate study to evaluate the rates for certain home and community-based services. We believe this could provide credible information

to lawmakers to consider adjusted rates, improving the stability of the program and producing potential savings.

- Counties support efforts to clarify standards and increase documentation through electronic visit verification in ways that do not overburden providers. We think this would result in more consistent assessment results and rates that more accurately reflect the needs of the individual. Over time, this could also produce savings. **[Article 6, Sections 5-12 and 28]**
- We would also encourage this committee to look at other potential savings mechanisms that have been under discussion at the LTSS Advisory Council, such as elimination of LTSS loans, which could have savings of \$70 million; and modifying nursing facility level of care for BI and CADI waiver services, which may produce \$42-51 million in savings over the biennium.

#### Nonemergency medical transportation

Counties urge this committee to consider postponing implementation of 2025 legislation that was slated to establish a uniform nonemergency medical transportation (NEMT) program for all Medical Assistance enrollees. DHS was directed to contract with a vendor to manage this statewide program. During the interim, DHS indicated that counties would retain responsibility for administering ancillary services (meals, lodging, and parking).

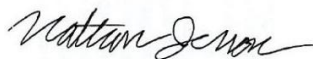
Counties believe that the legislative intent was to create a truly uniform NEMT program to reduce administrative complexity, ease navigation for residents, and strengthen oversight. DHS is in the process of issuing an RFP for fee-for-service enrollees (without inclusion of ancillary services) in advance of the July 1, 2026, effective date with an RFP for county-based purchasing plans (and managed care organizations) to follow in advance of its January 1, 2027, effective date. Counties encourage the legislature to consider postponing implementation for FFS enrollees until January 1, 2027, while allowing carve-out opportunities for county-based purchasing to adapt to specific community needs.

Chairs Noor and Schomacker, we appreciate that this proposal does not include additional cost shifts to counties, particularly considering uncertainty related to implementation of federal reforms and looming cost shifts authorized by the legislature in 2025. We recognize that you and your colleagues have great challenges before you. In addition to the priorities outlined here, we also want to underline the significant staffing and technology pressures on counties as we implement federal legislation (H.R. 1) and support program integrity. Conversations around many of these items are occurring in other legislative committees, but we want to highlight the importance of investments in staffing and technology to support our work to ensure that our system puts the needs of Minnesota individuals and families first – while also being responsible stewards of taxpayers' dollars by delivering transparent and efficient services. Please consider us a resource as you assemble your final proposals.

Sincerely,



Paul Verrette  
Executive Director  
MACSSA



Nathan Jesson  
Executive Director  
MICA

## Summary of a conversation on April 14th, 2026

**Subject: Proposed reduction of pre-approved IRTS stays from 90 to 30 days (HF 4338 DE Amendment)**

### Participants -

- Phillip Otterness, Behavioral Health Practitioner, 612-323-3234, p.otterness@gmail.com
- Shanda Powell, Behavioral Health Practitioner, 612-384-3951, shandapowell511@gmail.com
- Aaron Walker, Behavioral Health Practitioner, 952-688-9694, aaronwalker931@gmail.com
- Patrick Boerner, Office Manager, 320-282-7730, pmboerner@gmail.com

**All speaking on behalf of ourselves. AI generated summary based solely on 4/14/26 audio recording.**

Redacted Audio: <https://tinyurl.com/yhbsud6h>    Transcription: Descript    Summary: chatGPT

*This conversation circles around a central tension: meaningful human change takes time, while systems often demand speed, efficiency, and proof of value in compressed windows. What emerges is a layered, experience-driven argument for why 90-day IRTS programs matter—and why even they are often not enough.*



### 1. Trust, Safety, and the Hidden Timeline of Change

A core insight repeated throughout is that **progress in IRTS is often invisible at first**. Residents don't arrive ready to engage—they arrive guarded, disoriented, and often withdrawn.

“They just don't come right in communicating, laughing and talking... some of 'em have to adjust to their environment.”

Shanda reframes what might look like “lack of progress” as **necessary incubation**:

“It's more about them learning to re-adapt, learning to trust.”

Phil builds on this, naming a key pattern:

“It might be the third month where they come out of that shell... you don't always see the progress upfront.”

This is a powerful implicit critique of short-term models: **what looks like stagnation may actually be the precondition for growth**.



### 2. 30 Days vs. 90 Days: “The Tip of the Iceberg”

Aaron sharply challenges the idea that short-term care is sufficient:

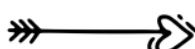
“30 days... that's not realistic at all... 30 days is the tip of the iceberg.”

The group converges on a shared understanding:

- **First phase:** acclimation, safety, basic trust
- **Second phase:** engagement, vulnerability, skill-building
- **Third phase:** identity, goals, future orientation

Even 90 days can feel compressed.

This highlights a systemic mismatch: **program timelines often end just as transformation begins**.



### 3. Peer Influence and “Contagious” Growth

One of the most compelling dynamics described is **peer-driven change**.

Phil observes:

“Residents who’ve been here a while... help build up the new people... kind of set the example.”

Shanda and Aaron expand this into a vivid model of social contagion:

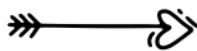
“They’ve been on both sides of the gate.”

“That person becomes like their flashlight for a while.”

“It becomes contagious.”

This suggests that IRTS isn’t just staff-driven—it’s an **ecosystem of modeled hope**, where:

- Trust spreads relationally
- Confidence is borrowed before it’s owned
- Identity is co-constructed through community



### 4. From Survival to Self-Worth and Vision

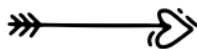
As residents stabilize, the shift isn’t just behavioral—it’s **aspirational**:

“Self-worth starts coming back... they care about being part of society... working, going to school.”

Shanda emphasizes that the goal isn’t just employment or compliance:

“Don’t just get a job... you have to find something you love.”

This reframes IRTS as not just recovery—but **reconnection to purpose**.



### 5. The System Problem: Discontinuity and the “Revolving Door”

Phil names a structural frustration:

“People just get flipped around like pancakes... you build trust and then... another provider.”

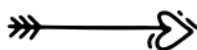
Aaron connects this to lived experience:

“This ain’t gonna last... there was always this little voice.”

This captures a deep attachment-level barrier: **even when trust is offered, it’s fragile because systems repeatedly break continuity**.

The result:

“When it doesn’t have time to kick in... it becomes a revolving door.”



### 6. The Case for Aftercare and Ongoing Belonging

A major insight emerges around what’s missing: **continuity beyond discharge**.

Shanda proposes a vision of extended connection:

“Come back and be speakers... check in... pick ’em up when they’re starting to doubt.”

She reframes the program as family:

“Checking in with your family... getting that extra boost.” Aaron: “head up, shoulders up, proud”

This suggests that the true value of IRTS may not just be the 90 days—but the **relational anchor it creates over time**.



## 7. What Actually Drives Change: Energy, Care, and Accountability

Beyond structure, the group emphasizes **relational and emotional factors**:

“They depend on me to be at my best. Energy is everything—people sponge off of people.”

“They feel like you care... your intent is good.”

“Accountability is everything.”

Phil synthesizes this into a key insight:

“It’s not just a specific skill—it’s an attitude. And that’s what actually changes people.”

This points to a subtle but crucial truth: **IRTS works not just because of what is taught, but because of how people are held.**



## 8. Translating This Into Policy: Time, Money, and Leverage

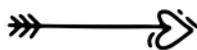
When shifting to legislative strategy, the group identifies what decision-makers care about:

- **Time realism** (meds take weeks, trust takes months)
- **Cost efficiency** (cheaper than hospitalization)
- **Outcome credibility** (real success stories)

Pat distills a sharp, pragmatic argument:

“They gotta [adjust to] their medicine... that can’t be done in 30 days... and we’re cheaper than hospitals.”

There’s a recognition that **values must be translated into the language of funding and systems.**



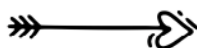
## 9. A Tone of Grounded Pride and Ongoing Aspiration

The conversation ends with a balance of humility and conviction.

“We’re all doing so much every day... we gotta give ourselves credit.”

But Phil also holds a growth mindset:

“There is *so much* potential in the IRTS model. Instead of hacking away at [it]... let’s ask, ‘How do we draw out the best of these programs?’”



## Core Throughline

If you had to compress the entire conversation into one idea, it might be this:

**Human change is relational, nonlinear, and time-dependent—yet the systems funding it often operate as if it should be fast, visible, and easily measurable.**

IRTS works because it **creates the conditions for trust, identity, and hope to re-emerge**—but its full potential depends on:

- thinking in terms of longer timelines with greater continuity,
- better integration within the wider social service ecosystem,
- and recognition that the most important outcomes often begin invisibly.



To: Chairs Schomacker and Noor, House Human Services Finance and Policy Committee

From: Brian Zirbes, MARRCH Executive Director

Subject: Public Testimony on [HF4338DE1](#)

Date: April 14, 2026

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MARRCH appreciates the opportunity to provide feedback and engagement on this human services funding bill. We support and encourage this committee's effort to improve program integrity and oversight. We want to ensure that potential changes have the right intended effect on enhancing oversight without undue burden.

Article 3—Section 5 Background Study Requirements for Peer Recovery Support (PRS) Services

PRS is built on lived experience, including justice system involvement. Broad application of background study requirements for clinical settings will disqualify many qualified peer specialists or require burdensome set-asides. This will reduce the workforce at a time when Minnesota is working to expand recovery support services.

This proposal would also impact AmeriCorps Recovery Corps members serving in peer roles. Recovery Community Organizations rely on AmeriCorps as a key workforce pipeline, and requiring DHS background studies for all members with direct contact may limit participation and placements in a federally funded program.

*We recommend delaying implementation of this requirement to take the time necessary to determine a better path forward that protects people being served while not inadvertently limiting workforce options. We also encourage this committee to consider increases appropriations to organizations that employ peers that may not be able to pass a background study.*

Article 4—Sections 1, 6-15: Behavioral Health

This proposal seeks a premature elimination of Free Standing Room and Board and moving up the Recovery Residence certification and requirements a full year. It was just during the last

legislative session that a Recovery Residence workgroup was created to develop recommendations for the 2027 Legislative session.

- Is this a recommendation from that workgroup? If not, what is the purpose of developing a workgroup if decisions preempt their work?
- Is a vendor already selected and ready to start certifying recovery residences by July 2026?

The appeal of grabbing savings through this proposal should be tempered with the awareness that this part of the treatment continuum has undergone substantial upheaval in the last year or so. *We would recommend keeping with the plan to allow the group of experts to discuss, evaluate, and develop recommendations for this body to consider in 2027.*

#### Article 6 Section 6: Electronic Visit Verification requirements

Line 201.8 notes: 'all unit-based services delivered by a provider type designated "high-risk" by the commissioner...' would imply that 245G (Substance Use Disorder) programs would be required to use EVV for all services they provide, even if they are not providing PRS. In 245G programs, PRS is an additional treatment service that they can provide or arrange for. *We recommend changing the language to, 'all unit-based services designated "high-risk" by the commissioner...'*

Thank you for your time and consideration. We stand ready to assist and provide any further information to support these critical changes.