DHS Budget & Forecast Updates
H.R. 1 Impacts on Medicaid

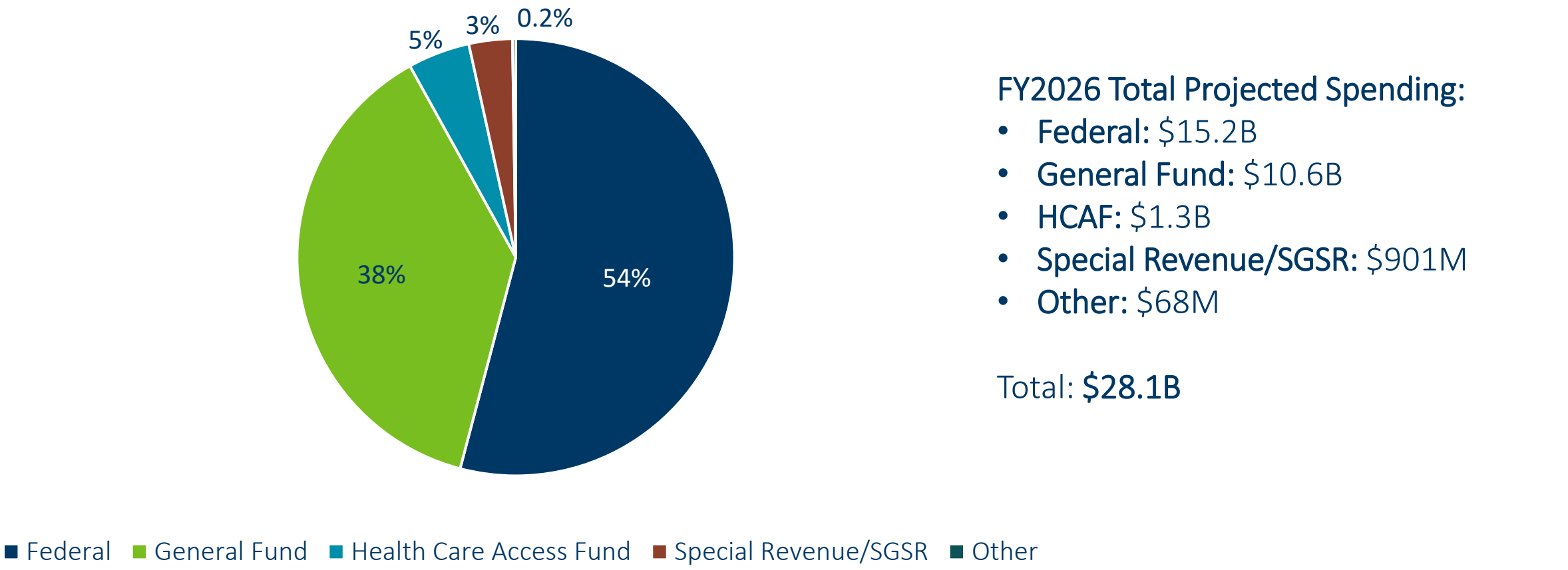
Health & Human Services Finance and Policy Committee
March 3, 2026

DEPARTMENT OF HUMAN SERVICES

DHS Budget

DHS Budget – Source of Funds

FY2026 Projected Expenditures by Funding Source

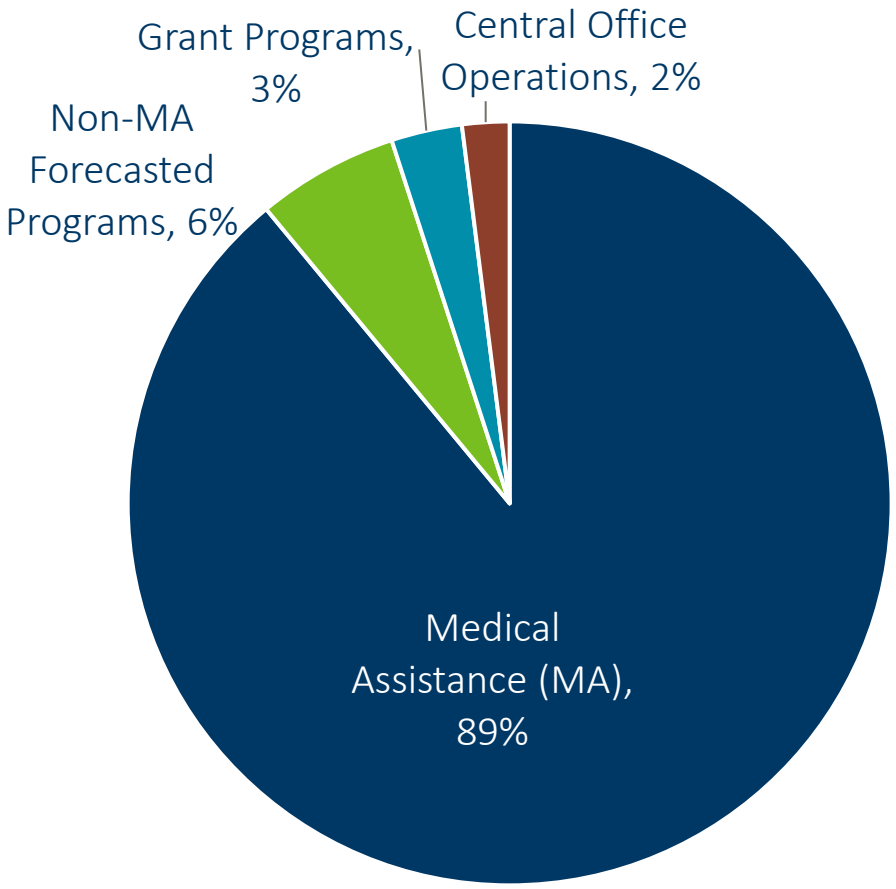


FY2026 Total Projected Spending:

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

Total: **$28.1B**

DHS Budget – How it is spent



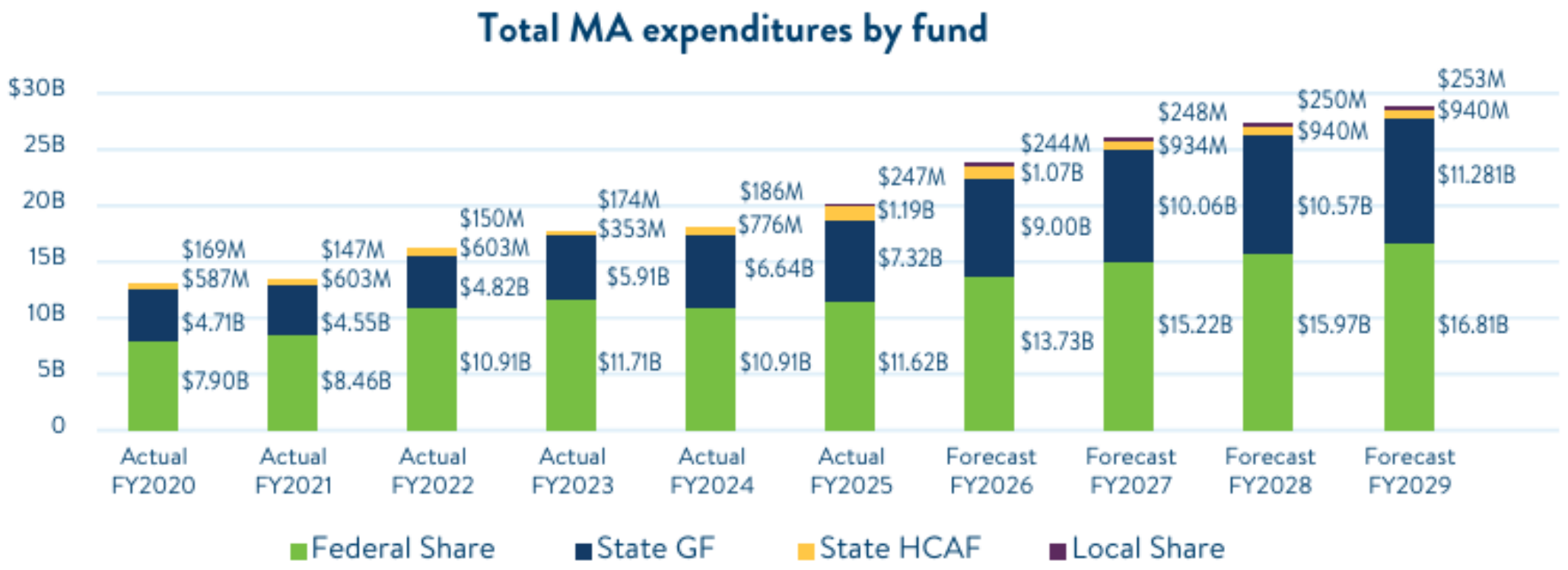
95% of the budget is spent on Forecasted programs, including:

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

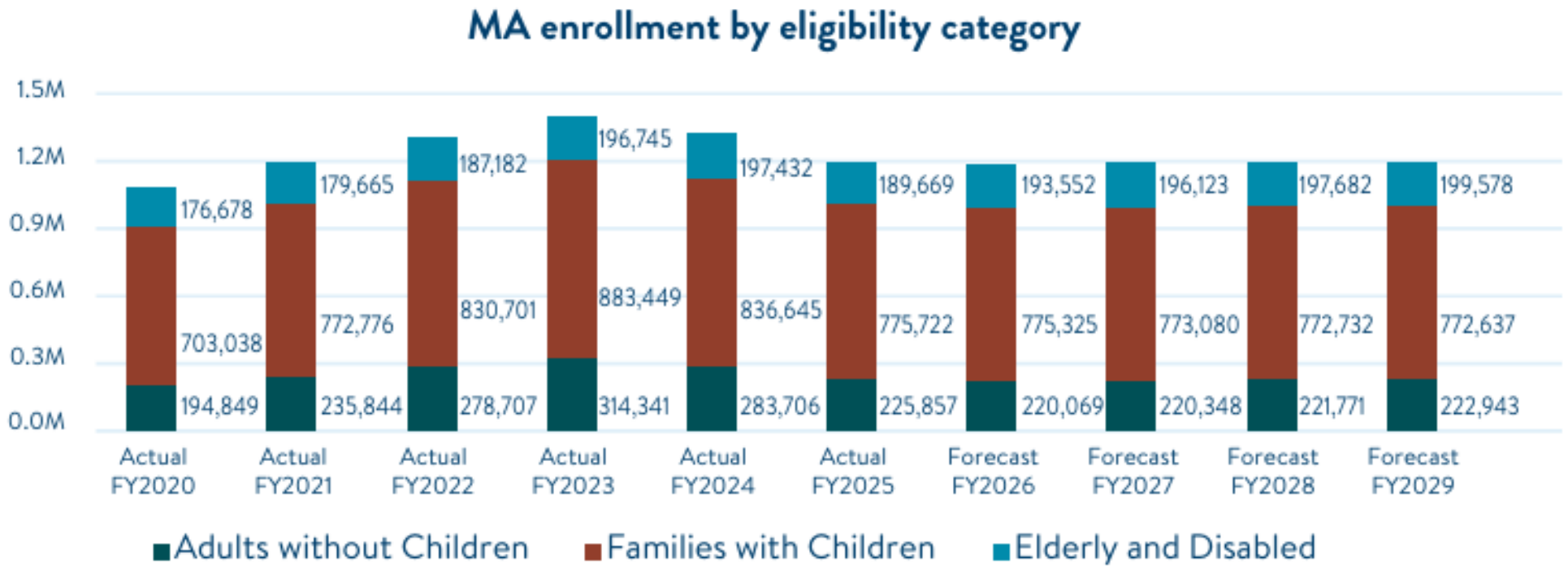
3% of the budget is spent on grants

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

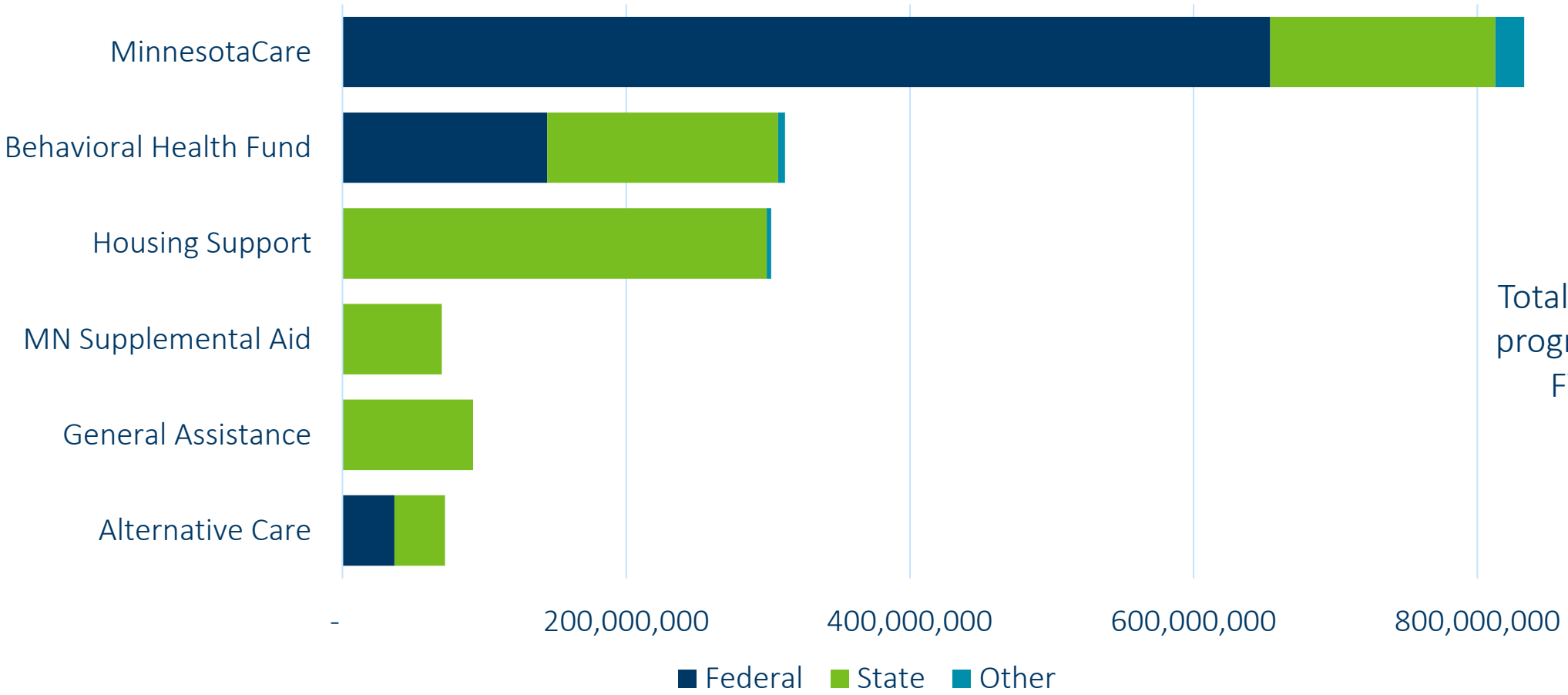
Medical Assistance Expenditures by Fund



Medical Assistance Enrollment Over Time



Non-MA Forecasted Programs Expenditures – FY 2026

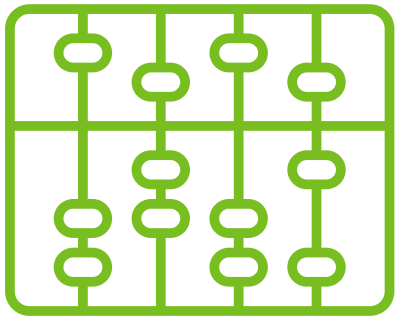


$1.7B

Total Non-MA forecasted programs **expenditures** in FY2026 (all funds)

November Forecast

November Forecast



The November Forecast:

- Measures differences between the End of Session Forecast (February forecast + changes made in the 2025 legislative session) to updated spending projections
- Projections are updated based on:
  - Updated claims (people served and amounts paid)
  - Implementation changes
  - Federal changes

Summary of Changes in November Forecast

	FY24-25	FY26-27	FY28-29
General Fund Total	79.8	1,416.3	1,327.8
	0.5%	7.6%	6.3%
Health Care Access Fund Total	10.7	253.1	404.9
	0.5%	11.5%	19.2%

General Fund: MA Basic Care MCO Payments

MA Basic Care Managed Care Rate Adjustments
6.1 million in FY24/25, 742 million in FY26/27, and 833.9 million in FY28/29

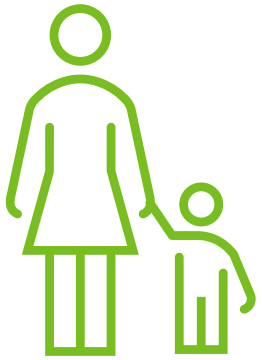
- 80% of Minnesota's MA basic care is paid for through Managed Care Organizations
- Capitation rates for managed care organizations are required to be actuarily sound
- To meet this requirement, Minnesota had to update capitation payments in based on utilization and costs from updated data
- Capitation rate changes vary by eligibility group, averaging 16%
- This rate of growth is not isolated to MA as other public and private insurance plans are seeing significant increases as health care normalizes after the COVID-19 pandemic (Dept. of Commerce seeing an average 22% increase for marketplace plans, SEGIP is seeing an increase of 17%, and this is consistent with national trends)
- Accounts for 56% of the change in the DHS 2025 November forecast

General Fund: MA Basic Care Fee-For Service and MA Enrollment

MA Basic Care Fee-For-Service Average Payments

$61.5 million in FY24/25, $166.8 million in FY26/27, and $168.7 million in FY28/29

- Updated claims have shown higher average payments
- Increases occurred in all eligibility groups, varying as follows:
  - Elderly and Disability: 3% increase
  - Adults without Children: 4% increase
  - Families with Children: 1% increase



MA Enrollment

$47.2 million in FY24/25, $194.5 million in FY26/27, and $158.9 million in FY28/29

- One year after the post-pandemic unwinding period, reflects updated enrollment
- Higher enrollment for people with disabilities (5%) and families with children (1.5%)
- Lower enrollment for older adults (-2.5%) and adults without children (-2.5%)
- Accounts for 14% of the change in the DHS 2025 November forecast

General Fund: Changes due to Federal Passage of HR1

Federal MA Basic Care Changes

$10.9 million in FY26/27 and $84.6 million in FY28/29

These changes are the result of the following provisions the Federal Government passed in HR1:

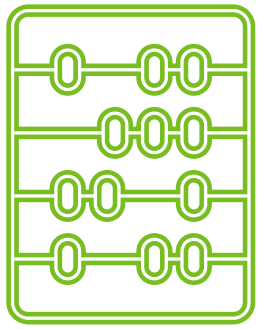
- **Change to retroactive coverage:** $12m in FY26/27 and $80m in FY28/29
- **Lawful immigrants accessing Medical Assistance:** -$12m in FY26/27 and -34m in FY28/29 (corresponding increase in HCAF of $36m in FY26/27 and $103m in FY28/29)
- **Federal match of Emergency Medical Assistance:** $10m in FY26/27 and $39m in FY28/29

Not included in the forecast:

Provisions that require state law changes to effectuate are not included in this forecast. Includes:

- **Work requirements** required by January 1, 2027
- **Cost sharing requirements** for adults without children

General Fund: MA Regular Federal Matching Rate



Federal Matching Rate Increase
-$108.9M in FY26/27 and -$336.8 million in FY28/29

- CMS updates the federal matching rate each year based on how the state's per capita personal income compares to the national average personal income
- Starting in October 2026, Minnesota's matching rate will change from 50.68% to 51.36%
- This change reduces the state share contribution for most populations and services in the program

Health Care Access Fund

MinnesotaCare HCAF Changes
$10.7M in FY24/25, $253.1M in FY26/27, and $404.9M in FY28/29

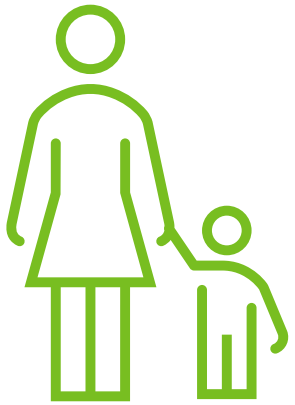
Change	Impact Over Budget Horizon
Managed Care rate adjustments of 18% based on updated plan cost experience	$555M
HR1 MA eligibility changes for lawful immigrants	$140M
Higher BHP funding due to 2026 market premium increases	-$420M
Lower BHP funding due to HR1 Advanced Premium Tax Credit (APTCs) changes	$433M
Other changes include changes in case mix, as we are serving more families who have lower costs and fewer adults with higher costs	-$39M

February Forecast

General Fund: Key Changes in the February Forecast

	FY24/25	FY26/27	FY28/29	Forecast Horizon
MA Enrollment	0	-29.1	-41.1	-70.2
Pre-Payment Review Process	0	-132.9	-104.8	-237.7
Other Changes	0	14.1	-29.1	-15
Total	**0**	**-147.9**	**-175**	**-322.9**
% Change		**-0.70%**	**-0.80%**	

Changes in MA Enrollment



MA Enrollment

-29.1 million in FY26/27 and -41.1 million in FY28/29

- 0.8% increase in enrollment for older adults
- -1.0% decrease in enrollment for adults without children
- -0.7% decrease in enrollment for families with children

Prepayment Review Process

Prepayment Review Process
-$132.9 million in FY26/27 and -$104.8 million in FY28/29

Timing: 2-week delay in payments for 14 high risk services results in a one-time reduction of -$53M in FY26/27

Denials: For the first warrant cycle in February, 0.2% denials occurred. Forecast assumes that this is ongoing with the prepayment review cycle, resulting in -$5M in FY26/27 and -$6M in FY28/29

Cost Avoidance: Fewer claims submitted by providers during the prepayment review process, resulting in 4% less spending for the 14 high risk services. Forecast assumes that this is ongoing, resulting in -$75M in FY26/27 and -$99M in FY28/29

Other Changes Impacting General Fund

Nursing Facility Surcharge Changes due to HR1:
Expenditure Forecast: -12.8M in FY26/27 and -33.4M in FY28/29
Revenue Forecast: 44M in FY26/27 and 118.3M in FY28/29

Adjustment to Calculating Impact of Retroactive Eligibility:
-3.2M in FY26/27 and -20.7M in FY28/29

Housing Support – More people, lower payments:
12.9M in FY26/27 and 22M in FY28/29

HCAF Fund: Key Changes in the February Forecast

	FY24/25	FY26/27	FY28/29	Forecast Horizon
Changes in Average Payments	0	8.8	8.6	17.4
Additional federal BHP funding	0	-11	0	-11
Other Changes	0	-4.5	4.4	-0.1
Total	**0**	**-6.8**	**13**	**6.3**
% Change		**0%**	**-0.30%**	**0.50%**

What is Not in the Forecast

The November and February forecasts do not include:

Some HR1 Requirements: Does not include HR1 changes that require state law changes to effectuate

Withhold of Federal Matching Funds: Does not include the federal government's notice to withhold $515 million in federal funding per quarter

Deferral of Federal Matching Funds: Does not include the federal government's notice of deferral of $259 million

HR1 Overview

Overview

H.R. 1

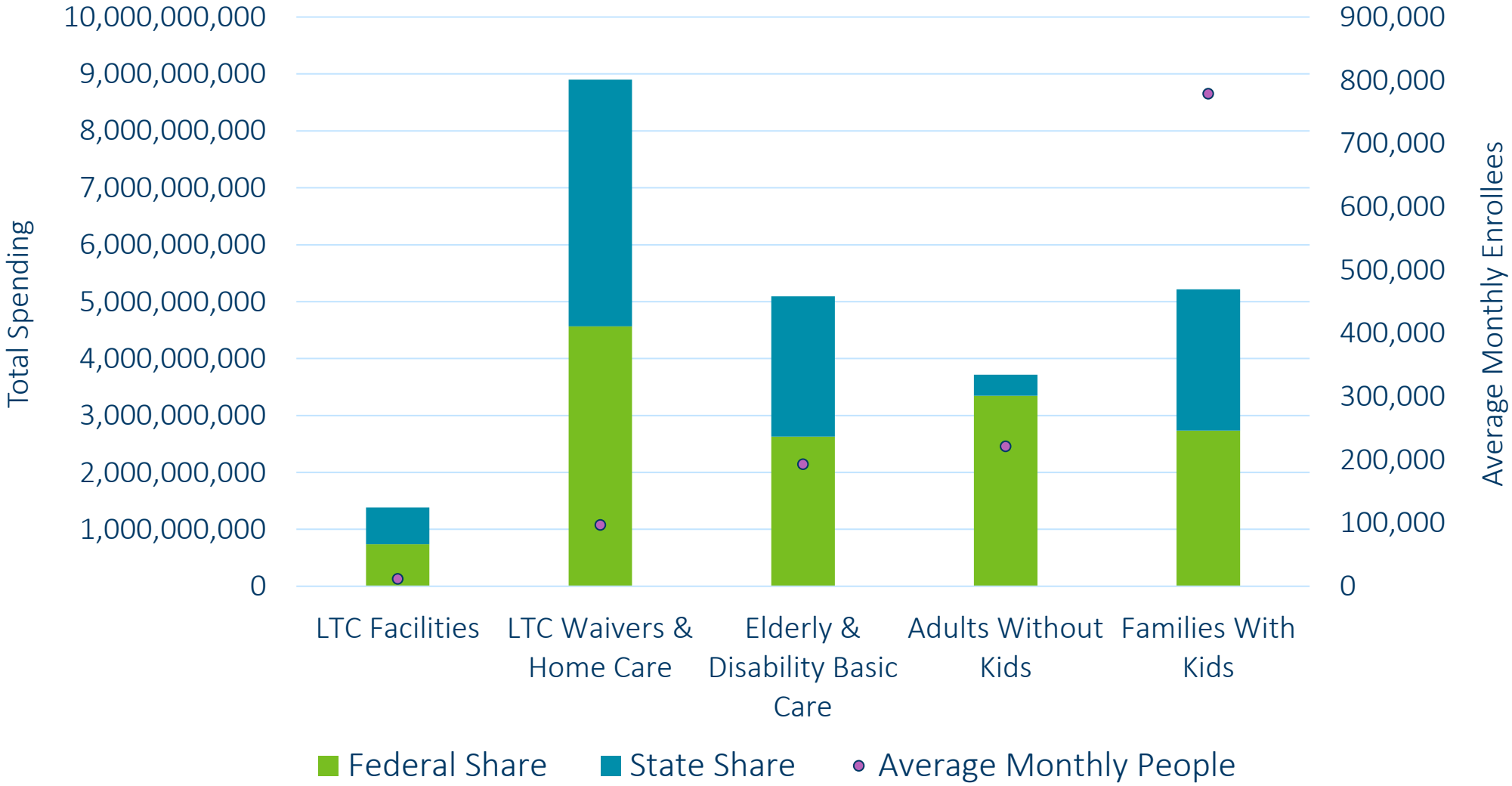
On July 4, 2025, Congress passed H.R. 1 which made sweeping changes to Medicaid.

These changes will:

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

Changes include, but are not limited to:

- Work requirements
- 6-month renewals
- Cost sharing requirements
- Changes to retroactive coverage
- Changes to eligible lawful immigration statuses
- Changes to federal funding
- Limitations on health care taxes



1.2 million average monthly enrollees

$24 billion total dollars

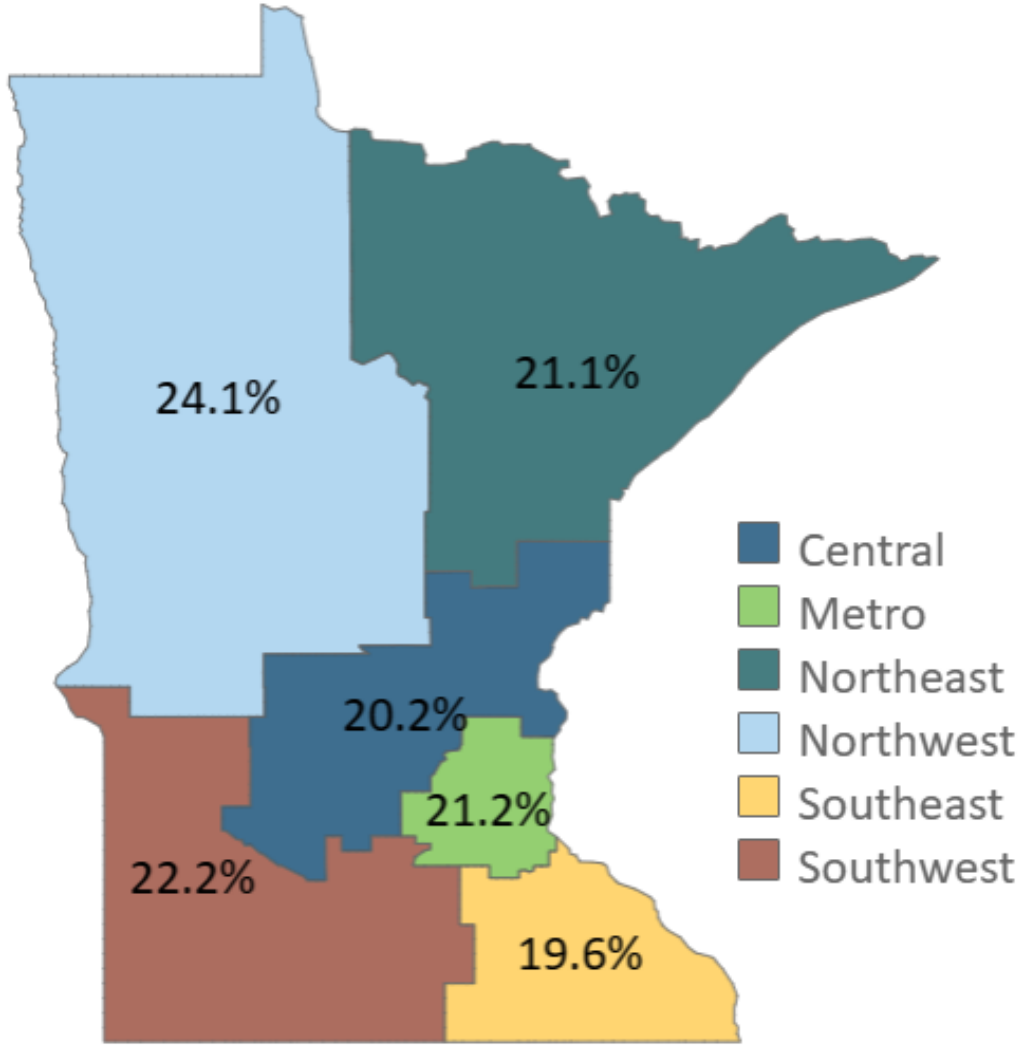
57% of spending funded by Federal Funds

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

Minnesota's Adult Expansion Group

In Minnesota, the adult expansion population refers to Medical Assistance enrollees aged 21 to 64 who do not have dependent children, are not pregnant, and are not receiving MA based on a disability.

MA Coverage Category	Adult Expansion Group?
Pregnant	No
Child born to a person enrolled in Medicaid	No
Infant	No
Child, age 2-18	No
Child, age 19 & 20	No
Parent/Caretaker	No
Former Foster Care Youth	No
Age 65 or older	No
Blind	No
Disability	No
Adult, age 21 through 64	Yes



Population Served by Medicaid (FY24)

H.R. 1 Changes to Medicaid

Work reporting requirements

H.R. 1 Change:	MA applicants and enrollees who are ages 21-64, who do not have children, are not pregnant and not seeking MA based on disability, also known as Minnesota's expansion population, will be subject to work/community engagement requirements if they do not meet an exemption.
Effective Date:	January 1, 2027
CMS Guidance:	CMS has released preliminary guidance, additional guidance and rulemaking is expected.
State Law Change:	Required for compliance.
Impact to MN:	Will result in loss of coverage and complexity in navigating eligibility for MA. Administrative complexity in eligibility determinations.
Fiscal Impact:	Reduced programmatic costs in MA for individuals losing coverage. Increased programmatic costs for individuals switching eligibility categories. Increased administrative costs for systems and eligibility processing.

Work reporting requirements: Qualifying Activities

To meet new requirements a person must be engaged in one of the following:

- Employment for not less than 80 hours in a month
- Community service for not less than 80 hours in a month
- Work program participation for long less than 80 hours in a month (including any program that qualifies as a SNAP work program)
- Enrollment in an educational program at least half-time as defined by the institution of higher education or career/technical education program
- Monthly income equivalent to at least 80 hours at federal minimum wage ($580 per month)
- Average monthly income over 6 months equivalent to 80 hours at federal minimum wage and is a seasonal worker

Work reporting requirements: Mandatory Exceptions

HR1 specifies which enrollees covered under Medicaid expansion are mandatorily exempted from work requirements. As noted earlier, many of these populations are already not considered part of Minnesota's expansion population:

- Individuals under age 19
- Pregnant individuals entitled to or enrolled in Medicare Part A or B benefits
- Foster youth
- Individuals enrolled in the Parents and Other Caretaker Relatives eligibility group
- Individuals eligible for a mandatory eligibility group (e.g., non-MAGI individuals)
- Individuals recently incarcerated in the previous three months

Work reporting requirements: Specified Excluded Individuals

HR1 provides a list of exempted populations from work requirements:

- American Indians, Alaska Natives, and California Indians
- Parents, guardians, or caregivers of dependent children 13 years or younger or disabled individuals
- Veterans with total disability ratings
- Former foster care youth under age 26
- Medically frail individuals or those with special medical needs
- Individuals complying with Temporary Assistance for Needy Families (TANF) work requirements
- Members of a household that is in receipt of Supplemental Nutrition Assistance Program (SNAP) and not exempt from SNAP work requirements
- Individuals participating in a drug addiction or alcohol treatment and rehabilitation program
- Inmates of public institutions
- Pregnant individuals or those receiving postpartum coverage

Work reporting requirements: Optional Exemptions

States are allowed at their discretion to offer other exemptions for a given month from a defined list of optional exemptions including the following:

- A person who received inpatient care at a hospital, nursing facility, or intermediate care facility,
- A person who lives in a county where there was an emergency or disaster declared by the President,
- A person who lives in a county that has an unemployment rate of 8% or 1.5 times the national unemployment rate (whichever is lower), or
- A person who had to travel outside of their community for an extended period of tie to receive medical services to treat a serious or complex medical condition.

Six-Month Renewals

Current State:	Annual renewals for Medicaid occur every 12 months.
H.R. 1 Change:	States must conduct eligibility redeterminations every six months for adult expansion enrollees who are not American Indian/Alaska Natives.
Effective Date:	January 1, 2027
CMS Guidance:	CMS published an informational bulletin; formal guidance is expected.
State Law Change:	Required for compliance.
Fiscal Impact:	Increased administrative costs for determining eligibility.

Retroactive Medicaid Eligibility

Current State:	Medicaid applicants may qualify for up to three months of retroactive coverage prior to the month of application.
H.R. 1 Change:	Retroactive Medicaid coverage is limited to one month before the date of application for the adult expansion population and two months for all other Medicaid eligibility groups.
Effective Date:	Jan. 1, 2027
CMS Guidance:	CMS published an informational bulletin; formal guidance is expected; additional guidance and revised rulemaking is expected.
State Law Change:	Absent a future state law change, retroactive coverage beyond the federal retroactive coverage period will be paid for with all state funds.
Impact to People:	Narrowing the period of retroactive coverage will lead to more uncompensated care for hospitals and providers and medical debt for low-income Minnesotans.
Fiscal Impact:	$8m in FY26/27 and $54m in FY28/29 (Feb. 2026 forecast)

Cost sharing in MA expansion population

	Requires states to impose cost sharing on Medicaid expansion adults with incomes over 100% percent of the federal poverty level.
H.R. 1 Change:	Cost Sharing Requirements: • May not exceed 5% of the individual's income or $35 per service • Exempt services: primary care, mental health, and substance use disorder services, as well as services provided by federally qualified health centers, behavioral health clinics, and rural health clinics • American Indians and Alaska Natives are exempt.
Effective Date:	October 1, 2028
CMS Guidance:	CMS published an informational bulletin; formal guidance and revised rulemaking is expected.
State Law Change:	Required for compliance.
Impact to MN:	Increased out of pocket costs for enrollees; increased uncompensated care for providers

Legal Noncitizen MA Eligibility Changes

Current State:	Currently, legal noncitizens are eligible for Medicaid coverage.
H.R. 1 Change:	Legal noncitizens age 21 or older who are not pregnant must have one of the following immigration statuses to qualify for Medical Assistance: Lawful permanent resident (LPR), Cuban or Haitian Entrant, or Compact of Free Association (COFA) Migrant.
Impacted People:	People losing Medicaid coverage include refugees, humanitarian parolees, asylum grantees, certain abused spouses and children, and victims of human trafficking. In MN, people may be eligible for state-funded MinnesotaCare.
Effective Date:	Oct. 1, 2026
CMS Guidance:	CMS released preliminary guidance regarding this change, further guidance and revised rulemaking expected.
State Law Change:	Technical change recommended.
Fiscal Impact:	Nov 2025 Forecast: • GF: -$12m in FY26/27 and -$34m in FY28/29 • HCAF: $36m in FY26/27 and $103m in FY28/29

Provider Taxes: Changes to Safe Harbor Limit & Limits to New Taxes

Current State:	Regulations permit states to tax health care providers up to 6% of taxable revenue.
H.R. 1 Changes:	**Restrictions on Taxes:** Starting October 1, 2026, states cannot impose new or increased provider taxes that were not enacted or in effect as of July 4, 2025. **Safe Harbor Limit Phasedown:** For Medicaid expansion states like Minnesota, the hold-harmless threshold for provider taxes will decrease by 0.5 percentage points annually, starting in fiscal year 2028, reaching 3.5% in 2032. This provision does not apply to not apply to nursing facilities and intermediate care facilities for persons with developmental disabilities.
Effective Date:	Prohibition of new taxes became effective upon enactment, July 4, 2025. The safe harbor limit for provider taxes begins to phases down on Oct. 1, 2028.

Provider Taxes: Changes to Safe Harbor Limit & Limits to New Taxes (cont.)

CMS Guidance:	CMS published an informational bulletin; formal guidance and revised rulemaking is expected.
State Law Change:	Future law changes may be needed.
Impacts to MN:	Minnesota passed an inpatient and outpatient directed payment in 2025. This tax waiver, if approved, will not be allowable after October 2026. This will reduce expected funding to hospitals. In 2025, Minnesota also increased surcharges, along with a corresponding rate increase, for nursing homes. If approved, this will not be allowable after October 2026 and will impact the amount of federal funding received by the State. Additionally, once the hold harmless limit begins to drop in 2028, the state may have to lower current tax rates and potentially reduce payments to hospitals that are financed by a portion of the hospital taxes.

Provider Taxes: Statistical Test

Current State:	Current regulations describe a statistical test that states must pass to be granted a waiver of nonuniform provider taxes. The test fails to control for certain tax programs that collect Medicaid revenues disproportionately relative to other payers.
H.R. 1 Change:	This legislation added requirements that must be met to qualify for a waiver. Tax programs that assess a rate on Medicaid revenues that is higher than other payers will not be allowed, even if the tax program passes the statistical test.
Effective Date:	This new requirement became effective with the enactment of the federal law.
Impact to MN:	Prohibits federal approval of a new managed care tax enacted by the legislature in 2025.

State-Directed Payments

Background:	State-directed payments (SDPs) are provider payment arrangements through managed care.
Current State:	Medicaid rules allow states to establish SDPs for hospitals, nursing facilities, and academic medical centers up to the average commercial rate.
H.R. 1 Change:	This provision lowers the federal limit on SDPs to these providers to: • Expansion states are limited to paying 100% of Medicare rate • Non-expansion states limited to paying 110% of Medicare rate
Effective Date:	The new limits were effective upon enactment, July 4, 2025, for new payments. However, existing approved payments and those payments currently under review by CMS must phase down the payments by 10 percentage points annually starting in 2028 until the SDP is equal to the new limit.
CMS Guidance:	CMS has released preliminary guidance, and additional guidance is expected.
State Law Change:	Required for compliance
Fiscal Impact:	Pending CMS review of outstanding requests and actuarial analysis

Reduced funding for Emergency Medical Assistance

Background:	Emergency Medical Assistance (EMA) covers emergency care services for people who meet financial and other requirements for Medical Assistance but are ineligible for coverage because of their immigration status.
Current State:	Currently, the state receives a federal match of 90% for the Adults with Children population.
H.R. 1 Change:	Reduces the match rate to a state's base Federal Medical Assistance Percentage amount (in Minnesota this is just over 50%).
Effective Date:	Oct. 1, 2026
CMS Guidance:	CMS has released preliminary guidance.
State Law Change:	Not required for compliance.
Fiscal Impact:	$10m in FY26/27 and $39m in FY28/29

Reduced funding related to Medicaid payment errors

Current State:	Section 1903(u) of the Social Security Act requires each state to report the ratio of its erroneous excess payments under the state plan to its total Medicaid payments. Payments for people ineligible for the program or overpayments for eligible people in excess of the 3%-error threshold during the fiscal year are considered overpayments. CMS may waive penalties where states demonstrate a good faith effort to correct payment errors.
H.R. 1 Change:	HR1 limits CMS' authority to waive penalties for eligibility errors in excess of the threshold and allows CMS to apply penalties to additional audits with findings related to errors.
Effective Date:	October 1, 2029
CMS Guidance:	States have not received guidance to date. CMS is expected to publish detailed guidance on this provision in the future.
State Law Change:	Not required for compliance. Administrative appropriation needed to mitigate errors.
Fiscal Impact:	Administrative costs anticipated. Programmatic impacts TBD.

Effective Dates

July 4, 2025

* Provider Tax Statistical Test Changes

October 1, 2026

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

January 1, 2027

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

January 1, 2028

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

October 1, 2028

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

October 1, 2029

* Medicaid payment errors changes

HR1 Implementation Efforts

Guiding Principles for Implementation

- Maintain coverage for eligible enrollees
- Comply with federal and state requirements
- Minimize burden on workforce
- Simplify process and align where possible
- Robust communications with impacted communities
- Uphold fiscal responsibility

Implementation

- To implement most of the HR1 provisions, DHS requires legislative authority, legislative appropriations, and additional guidance from CMS.
- Implementation is challenged by tight timelines to achieve federally required effective dates and competing priorities.
- Implementation requires changes to multiple systems, updating policy bulletins, updating worker procedures and training, and solidifying additional communications and outreach plans prior to implementation effective dates.

Implementation Timeline for Provisions with Large Systems Updates

Provision	Federal Effective Date	Systems Work Timeline
Noncitizen eligibility changes	October 1, 2026	December 2025 - October 2026
Work reporting/community engagement requirements	January 1, 2027	December 2025 – October 2026
Six-month renewals	January 1, 2027	December 2025 - October 2026
Retroactive eligibility changes	January 1, 2027	April 2026 - December 2026
Reinstate cost sharing	October 1, 2028	TBD

Engagement Strategies

Leveraging Existing Engagement Structures
Engage stakeholders through existing communication and governance structures to support timely awareness and readiness while maintaining alignment with federal implementation timelines.

Aligning Stakeholder Engagement to Federal Implementation Dates
Create targeted and meaningful engagement opportunities with partners to share information as quickly as possible and gather feedback without introducing delays to implementation.

Standardizing messaging to Promote Consistent Understanding Across Partners
Ensure that information sharing and engagement are aligned and coordinated so to not introduce confusion.

Recipient and Enrollee Outreach

DHS is using strategies from the end of the COVID-19 Public Health Emergency including:

- Collaboration and information sharing with impacted partners, including County and Tribal governments
- Mailings and text messages to impacted enrollees
- Centralized webpage of changes and actions needed
- Partner toolkits:
  - One pagers and informational fliers
  - Call center scripts
  - Fact sheets
  - Material for text messages and social media

Risks of Non-Compliance

Lack of compliance puts federal financial participation at risk.

- State law changes are required for compliance with new federal requirements.
- CMS is monitoring state's implementation of these new requirements.
- H.R.1 changed improper payment audit calculations, lowering the threshold of error to avoid federal recoupment penalties.

Thank You

Federal Changes Summary

Medicaid by the Numbers

Medicaid data by region

DHS Reports and Forecast