DEPARTMENT OF HUMAN SERVICES

Minnesotans, Medicaid, and the Implications of the 2025 Federal Reconciliation Law (P.L. 119-21)

Reductions on Retroactive Medicaid Coverage Protections

5/21/2026

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Dear colleagues, community partners, and readers:

As a physician, a father, and the Medical Director of Minnesota's Medicaid program, I see every day how essential Medicaid is to the health and stability of our communities. I have watched the relief on a mother's face when she learned her child's care would be covered by Medicaid, allowing their family to get what they need to stay healthy and thrive. I have heard the worry in the voices of patients who lost Medicaid coverage and didn't know how they were going to get needed care.

Medicaid is truly the backbone of our health care system. It ensures access to care for children, adults, elders, and people with disabilities in all communities in our state. When Medicaid is cut, the consequences ripple far beyond individual families; clinics and hospitals face financial strain, services shrink for those with and without Medicaid, and long-standing inequities deepen.

In my work at the Department of Human Services, I have seen how well-intended policies can unintentionally reinforce inequities. I have also seen how meaningful community partnership and intentional co-creation can reshape those policies and begin to reverse disparities. This equity analysis is rooted in that commitment: to listen, to learn, and to inform the design of policy that can move us toward a more just, equitable health system.

This analysis comes at a time of great uncertainty. It's clear that the federal reconciliation bill signed into law on July 4, 2025, under Public Law 119-21 marks the largest cuts to Medicaid in history, but final guidance from the Centers for Medicare & Medicaid Services (CMS) has not yet been issued. Many of the unanswered questions, especially around implementation, will directly affect the health and wellbeing of people throughout our state.

These unanswered questions create challenges in planning and communication, but they also underscore why it is important to lift up potential equity implications now, while policy decisions are still being made. By naming some of the potential equity impacts now, we aim to ensure that communities most impacted by changes to MN Medicaid are centered throughout the ongoing decision-making and implementation process.

The estimates and considerations included here are not exhaustive or prescriptive. Our goal is to support thoughtful, informed choices that align with Minnesota's commitments to equity, inclusion, and authentic community partnership.

The hope is this analysis helps guide the work ahead as we strive to shape policies that promote fairness, dignity, and wellbeing for all Minnesotans.

In Solidarity,

Nathan T. Chomilo, MD, FACP
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Executive summary

The Minnesota Department of Human Services' Medicaid (Medical Assistance) and MinnesotaCare programs serve 1.3 million people (22% of all Minnesotans), including children, parents, seniors, and people with disabilities, and help the state keep an historically low uninsured rate.

Federal Medicaid cuts signed into law July 4, 2025, under Public Law 119-21 (P.L. 119-21, the "One Big Beautiful Bill Act") will make it harder for some Minnesotans to get, keep, or afford their health insurance. **The Minnesota Department of Human Service estimates that up to 140,000 people could lose Medicaid coverage under P.L. 119-21**, intensifying pressure on safety-net hospitals and clinics.

Under current law, **retroactive Medicaid coverage protects low-income people from health care bills** by paying for care received up to three months before their enrollment, including bills for emergency care, hospitalizations, care for chronic conditions, and new diagnoses.

Beginning January 1, 2027, Congress' 2025 cuts to Medicaid reduce this safeguard to one month for adults without dependent children or certified disabilities and two months for all other groups. The 2026 Minnesota Legislature passed legislation that fully funds three months of Medicaid retroactive coverage for Minnesotans for an additional year with state dollars. **That means in Minnesota the changes to retroactive coverage are scheduled to begin Jan. 1, 2028.**

While the law applies "neutrally" to all eligibility groups, **its impact is not neutral**. It shifts financial and health risks onto the communities already most disadvantaged as well as onto safety-net providers, undermining Minnesota's "One Minnesota Plan" equity goals. This change will increase medical debt for some enrollees and raise uncompensated care for providers, with disproportionate impacts on rural, Black, American Indian, immigrant, disabled, and LGBTQ+ Minnesotans, who already face enrollment barriers and health inequities.

Shortening retroactive coverage weakens the buffer against life instability, paperwork delays, or sudden illness. This creates long-term financial consequences for Minnesotans — unresolved medical debt is associated with worse access to future care, stress, and broader economic instability — as well as for safety-net providers, who already operate on razor thin margins.

Retroactive coverage costs less than 1% of overall Medicaid spending, but in State Fiscal Year 2024, it prevented almost $130 million in unpaid medical bills. Under P.L. 119-21, this protection would shrink to an estimated $93 million, a loss of nearly $37 million, or about a 29% reduction in retroactive payments, exposing vulnerable Minnesotans and safety-net providers to debt and financial strain. **In one-year, low-income Minnesotan children and families will pay an estimated $5.4 million more out of pocket from these Medicaid cuts, adults without dependent children will pay an estimated $27.9 million more, and seniors and people with disabilities will pay an estimated $3.9 million more.** The poorest Minnesotans will take on this added economic debt to finance tax breaks for the wealthiest.

Without intervention, reducing retroactive coverage is likely to widen existing disparities.

- **For enrollees.** Populations already at higher risk of chronic conditions, such as American Indian, Black, and Native Hawaiian/Pacific Islander Minnesotans, face greater exposure to medical debt.

- **For providers.** Safety-net providers, especially rural critical-access hospitals, federally qualified health centers, and long-term care facilities, will face rising uncompensated care burdens. Minnesota's rural hospitals already operate on narrow margins; additional revenue loss may trigger service reductions or closures, further decreasing access to care for everyone, whether they are covered by Medicaid or not, in high-need communities.
- **For the system.** Increased churn and administrative stress could overwhelm State and county systems and lead to delays in application processing for enrollees.
- Policymakers should consider **expanding community-based navigation support, and monitoring equity impacts** to align with the State's "One Minnesota Plan" equity goals.

Call to action

To protect health equity in Minnesota and mitigate harm from retroactive Medicaid coverage cuts in Public Law 119-21, **the following actions are critical:**

- **Invest in priority outreach and navigation support** through community-based organizations, especially for Black, American Indian, Pacific Islander, immigrant, rural, and LGBTQ+ communities most at risk of losing access or incurring medical debt.
- **Track and respond to equity impacts** through public data monitoring, community engagement, and alignment with the State's One Minnesota equity and Medicaid reform goals.
- **Allocate targeted resources** to offset uncompensated care for Critical Access Hospitals and Federally Qualified Health Centers, ensuring these essential providers can continue delivering lifesaving services in rural and disadvantaged communities.

Explanation of terms

Medicaid and Medical Assistance

Minnesota's Medicaid program is called Medical Assistance, often abbreviated as MA. Medical Assistance is the state's largest public health care program, providing coverage for children and families, pregnant people, adults without children, older adults, and individuals who are blind or have disabilities.

This Minnesota Department of Human Services equity analysis examines the effects of federal changes to the Medicaid program under Public Law 119-21. Throughout this analysis, the term "Medicaid" is used intentionally. This reflects both the terminology used in federal regulations and the connection between federal policy and Minnesota's State program, Medical Assistance.

While Minnesotans may be more familiar with the term Medical Assistance, it is important to understand that references to "Medicaid" in this document refer to Minnesota's Medicaid program, Medical Assistance. Using the federal term helps clearly link national policy changes to their local impacts in Minnesota.

Public Law 119-21

H.R. 1, titled the "One Big Beautiful Bill Act," became Public Law when signed on July 4, 2025. Throughout this equity analysis, the terms "Public Law 119-21" or "P.L. 119-21" are used to refer to the federal H.R. 1 Medicaid cuts signed into law July 4, 2025.

Understanding the human impact of the federal cuts to Medicaid

**Note: Case examples and vignettes below represent realistic yet hypothetical scenarios that demonstrate the potential impact that shortening retroactive coverage has on communities.*

Without additional support

Maria, a 54-year-old mother of adult children and member of the White Earth Nation, lives in Mahnomen County, where nearly half of residents depend on Medicaid. She has diabetes and housing instability. In December 2027, Maria gets hospitalized for diabetic ketoacidosis but only applies for Medicaid in February 2028 after finally feeling better and getting her paperwork together with help from a friend.

- **Before federal Medicaid cuts**, Maria's hospitalization in December gets covered retroactively, preventing medical debt.
- **Under federal Medicaid cuts**, with only one month of retroactive coverage for adults without dependent children, Maria's December hospitalization falls outside the window of protection. The hospital discharges Maria with a $38,000 bill. The local critical access hospital absorbs much of this cost as uncompensated care, further straining its budget. Maria now avoids follow-up visits because of fear of debt collectors, worsening her health outcomes.

James, a 62-year-old farmer with adult children in northern Minnesota, lives in Beltrami County where more than 32% of residents rely on Medicaid. James has no internet access at home, making online Medicaid applications difficult. In March 2028, James requires hospitalization for a serious infection, but he does not submit his Medicaid application until June when his daughter helps him at the county office.

- **Before federal Medicaid cuts**, his March hospitalization gets covered under the three-month retroactive period.
- **Under federal Medicaid cuts**, with only one month of retroactive coverage for adults without dependent children, James' March stay no longer qualifies for reimbursement. He receives a $21,000 bill, which he cannot pay. The local critical access hospital absorbs the loss, deepening its financial strain. Already facing workforce shortages and thin margins, the hospital reduces weekend urgent care hours to cut costs. This forces James and his neighbors to drive more than 70 miles to the next nearest emergency facility.

Shortened retroactive coverage disproportionately harms rural residents, who already face barriers such as broadband gaps, provider shortages, and long travel distances. The policy not only burdens individuals with medical debt but destabilizes the rural hospitals depended on by communities who live there.

George, a 70-year-old retired mechanic and Medicare enrollee, lives alone in rural Becker County, Minnesota, where the nearest hospital and long-term care facility are vital lifelines for the aging population. In April 2028, George suffers a fall at home, leading to a hip fracture. He is hospitalized for surgery and recovery, then discharged to a nearby skilled nursing facility for rehabilitation. Because of confusion about what Medicare may cover, and lack of information about eligibility for Medicaid, as well as no family to assist, George doesn't complete his Medicaid application until July 2028.

- Before federal Medicaid cuts, George's April and May skilled nursing facility care are covered retroactively, preventing a financial crisis for both him and the facility.
- Under federal Medicaid cuts, with only two months of retroactive coverage for seniors and people with disabilities, George's April skilled nursing facility stay no longer qualifies for Medicaid reimbursement. George receives a bill for more than $15,000, which he cannot pay with his fixed income. George faces aggressive collection notices and is reluctant to return for follow-up care, increasing his risk for complications and rehospitalization.

  The skilled nursing facility absorbs the cost, deepening financial strain and placing it at risk of closure, threatening services for other patients in the community.

With targeted mitigation

Ahmed, a 29-year-old Somali Minnesotan in Rochester, loses his retail job and health insurance. In July 2028, he needs hospitalization for pneumonia but does not apply for Medicaid because he does not know he qualifies.

- With support from a **community-based navigator**, Ahmed receives application help directly in the hospital. Ahmed's application is approved for Medicaid on the same day it is submitted.
- **Outcome**: Because Minnesota invested in community-based navigators, Ahmed accesses timely Medicaid coverage. He avoids medical debt and maintains follow-up care, while the hospital is paid in full.

David, a 45-year-old white Minnesotan living in Duluth, loses his job and health insurance. In August 2027, he has an emergency room visit due to complications from asthma. David's health issues and economic instability prevent him from submitting a Medicaid application until October, two months after his emergency room visit. By then, he is diagnosed with several chronic conditions requiring ongoing care.

- **Outcome:** Because Minnesota preserved retroactive protections for an additional year, David's emergency room visit gets covered retroactively. David avoids thousands in medical debt, receives needed follow-up care, and through a combination of dedicated private and public funding, Medicaid pays the hospital in full.

Background and context

Minnesota's Medicaid and MinnesotaCare programs are cornerstones of the state's system of health and long-term care coverage, serving nearly 1.3 million people, including children, parents, people with disabilities, and

adults aged 65 or older. Enrollment spans all regions and demographics, but coverage is particularly concentrated among children, low-income parents, people with disabilities, and residents in Greater Minnesota. Roughly two-thirds of Minnesota's Medicaid enrollees are parents, children, and pregnant people. Currently, 23% of Minnesota's Medicaid enrollees are adults without dependent children who are not receiving Medicaid based on a disability. These adults gained eligibility to Medicaid through the expansion of insurance under the Affordable Care Act, so the population is sometimes referred to as the adult expansion population.[1]

While the majority of Medicaid enrollees identify as white, Medicaid plays an outsized role in providing coverage for Minnesotans who identify as Black, American Indian, Asian, Pacific Islander, or multiracial, serving a larger proportion of these communities than their representation in the state's overall population.[1] In many Greater Minnesota counties, a higher percentage of the population is enrolled in Medicaid and MinnesotaCare compared to those in the metro area.[2]

Minnesotans <65 years old who access care via Medicaid	7-county metro	Greater Minnesota
American Indian/Alaska Native	32%	**43%**
Asian	**19%**	13%
Black/African American	41%	**48%**
Hispanic/Latinx	**27%**	23%
"Other"	19%	**22%**
White	7%	**12%**

Table 1: Many Greater Minnesota counties have a higher percentage of their population enrolled in Medicaid and MinnesotaCare compared to metro counties. Source: SHADAC analysis of the 2022-2023 American Community Survey (ACS) Public Use Microdata Sample (PUMS) files (MN Department of Human Services, 2025e).

Medicaid and MinnesotaCare contribute significantly to the state's health care sector, supporting public health infrastructure such as hospitals, mental health centers, home care, community clinics, nursing homes, physicians, dentists, and many other health professionals. Both programs help to significantly reduce the number of Minnesotans that go without health care coverage and serve as a lifeline to Greater Minnesota providers, decreasing the cost of uncompensated care and reducing the amount of medical debt owed by Minnesotans. Medicaid — not Medicare — is the primary source of coverage for people who need long-term care services. [1,3]

Medicaid provisions in the 2025 federal reconciliation law

The 2025 federal reconciliation bill was signed into law on July 4, 2025, under Public Law 119-21.[4] This comprehensive budget reconciliation package includes changes impacting taxation, immigration, education, social safety-net programs, and health care.[4] The law includes significant Medicaid cuts, with many provisions targeting adults without dependent children or certified disabilities (commonly known as the adult expansion population) by imposing stricter eligibility requirements, increased administrative burdens, and additional medical expenses.[4] The Congressional Budget Office estimates that 11.8 million people will lose Medicaid coverage nationally over the next ten years as a result of P.L 119-21.[5] The Department of Human Services estimates that eventually more than 140,000 Minnesotans will lose coverage as a result of P.L. 119-21.[6] In addition, the law imposes new restrictions on Medicaid financing flexibility, marking a historic disinvestment in the U.S. health care system. By shifting costs from the federal government to the State, local providers, and patients, the legislation threatens the financial viability of many rural and safety-net hospitals, which could lead to closures and reduced access for all community members, including those with employer-based insurance.[7]

What retroactive coverage does and how it will change

Retroactive Medicaid eligibility has been part of federal law since 1972, protecting people who were unaware of their eligibility for Medicaid or unable to apply in a timely manner, and allowing providers to begin needed care regardless of a patient's application date. Despite retroactive Medicaid coverage's long-standing role, research on its direct impacts to enrollees and providers is limited.[8]

Between 2017 and 2020, the federal government approved Section 1115 waivers limiting retroactive coverage for the Medicaid population in six states.[8] Five of these states ended up making changes to their Section 1115 waiver after implementation, re-extending the retroactive period or providing exemptions for certain groups, such as pregnant people, young children, and patients residing in nursing homes, suggesting that negative impacts were observed under reduced retroactive periods.[8]

What is retroactive coverage? Under prior law, states covered **up to three months** of eligible services before application if the individual would have been eligible for Medicaid during that time. This safeguarded people who qualified for Medicaid but had delayed their application, covering emergency stays, new diagnoses, and essential medications incurred shortly before applying. P.L. 119-21 narrows that protection.

What changed? For applications filed on or after January 1, 2027, P.L. 119-21, Section 71112 reduces Medicaid retroactive coverage from three months before the date of application to **one month** before application for low-income adults without dependent children or certified disabilities and **two months** for all other Medicaid eligibility groups (including children, pregnant people, seniors, and people with disabilities).[4] Final implementation is pending guidance from CMS. The 2026 Minnesota Legislature passed legislation that fully funds three months of Medicaid retroactive coverage for Minnesotans for an additional year with state dollars. **That means in Minnesota the changes to retroactive coverage are scheduled to begin Jan. 1, 2028.**

Why does it matter? Retroactive coverage protects people who qualify for Medicaid but experience delays in application due to barriers such as difficulty accessing documentation, life instability, or health crises. Shortening this period increases medical debt for the poorest Minnesotans and raises uncompensated care for providers by shifting the financial risk to enrollees and providers, especially safety-net hospitals and clinics.[1,9] Minnesota projects statewide fiscal losses tied to these and related provisions.

The shortened retroactive window magnifies risks for populations already facing structural barriers:[10–13]

- **Children and families** lose stability and protection during application delays tied to documentation, illness, moving between counties, or seasonal income shifts.
- **Adults without dependent children or certified disabilities** face the steepest reduction in coverage, exposing them to higher risk of medical debt, especially as more frequent renewal requirements increase the risk of gaps in coverage.
- **Black, American Indian, Hispanic/Latine, and Pacific Islander Minnesotans** face disproportionate burdens of poverty and chronic disease, making acute hospitalizations before application more common.
- **Rural and Tribal communities** risk further destabilized hospital and clinic systems when retroactive protections shrink.
- **Seniors, Minnesotans with disabilities, and people receiving long-term services and supports** face the potential for catastrophic out-of-pocket costs when nursing home or hospital stays occur slightly before coverage begins.

When it takes effect. Federal changes take effect for applications filed on or after Jan. 1, 2027. Because the 2026 Minnesota Legislature passed legislation that fully funds three months of Medicaid retroactive coverage for Minnesotans for an additional year using state dollars, **changes to retroactive coverage in Minnesota are scheduled to begin Jan. 1, 2028.**

Fiscal impact. Minnesota will lose nearly $37 million, or about a 29% reduction in overall retroactive payments, exposing vulnerable Minnesotans and safety-net providers to debt and financial strain.

Definitions of Medicaid enrollee eligibility groups and the impact of federal Medicaid cuts on retroactive coverage

Eligibility groups	Whom this includes	Coverage before federal Medicaid cuts	Coverage after federal Medicaid cuts	Why it matters
Children 	Children **under age 21** *(includes 19- and 20-year-olds in Minnesota, who qualify under the child pathway)*	Up to **3 months** before application	Up to **2 months** before application	Early coverage supports access to well-childcare, immunizations, and urgent needs. Shorter retroactive periods can leave recent emergency room visits or tests unpaid, which is especially consequential for rural, Black, American Indian, refugee, and immigrant families. *Minnesota treats 19-20-year-olds as children for Medicaid eligibility. This age group will be subject to the 2-month retroactive coverage rule rather than the 1-month rule for expansion adults.
Pregnant people 	People eligible for Medicaid during pregnancy and **12-months postpartum** continuous eligibility	Up to **3 months** before application	Up to **2 months** before application	This group often relies on retroactive coverage for preventive and maternal care and is protected from the high cost of prenatal, birth-related, and postpartum services by this coverage. A shorter retroactive window increases the chance that services right before enrollment go uncovered, raising financial stress and adding continuity-of-care risks.

Eligibility groups	Whom this includes	Coverage before federal Medicaid cuts	Coverage after federal Medicaid cuts	Why it matters
Parents & caretaker relatives 	Parents and caretaker relatives of dependent children	Up to **3 months** before application	Up to **2 months** before application	Parental and caretaker coverage stabilizes family access to primary and behavioral health care. Reduced retroactive coverage heightens exposure to medical debt if an acute event occurs shortly before applying.
Adults without dependent children or certified disabilities ("Expansion adults") 	**Ages 21-64**, not pregnant, not eligible on the basis of disability	Up to **3 months** before application	Up to **1 month** before application	This group will see the steepest reductions to retroactive coverage under P.L. 119-21. More recent pre-application hospital or clinic bills may go uncovered, increasing medical debt and uncompensated care. More frequent renewals (every six months) will increase coverage gaps, or "churn," for some and worsen these risks.
Seniors, people who are blind or who have disabilities 	**Age 65+** or individuals meeting disability or blindness criteria Many are dually eligible with Medicare. Income and asset rules apply.	Up to **3 months** before application	Up to **2 months** before application	This population of enrollees often requires ongoing care, medications, and coverage for services provided in a long-term care facility. A shorter retroactive window raises the risk that services provided shortly before enrollment go unreimbursed, adding financial strain to a population usually living on fixed incomes.

Equity impact assessment

Equity analysis framework

The Minnesota Department of Human Services' **Office of the Medicaid Medical Director** is committed to advancing equity by eliminating disparities based on race, ethnicity, age, abilities, veteran status, sexual orientation, geography, gender identity and expression, and intersecting identities. As such, a framework was developed to support equity-informed policymaking by evaluating how legislation may disrupt access to essential health services; exacerbate racial, gender, geographic, and socioeconomic health disparities; undermine legal and ethical standards related to reproductive and human rights; and disproportionately harm low-income and medically underserved populations and the health care providers who deliver their care.

This framework specifically focuses on building a better understanding of:

- The present understanding of the demographics of current Medicaid enrollees that will be affected by this legislation.
- Any existing disparities in the health or social outcomes of Medicaid enrollees that will be affected by this legislation.
- How these health inequities have been previously prioritized by community members, the State Legislature, and State government.
- The published evidence and traditional knowledge about the impact of this legislation on the affected population.
- Any alternative options for coverage for the affected group and how they compare with the original benefit.
- Resources needed to help build community understanding of this legislation.
- Ultimately, the main equity considerations and potential actions regarding funding cuts or investments in this eligibility group.

Profile of affected enrollees

While the law applies "neutrally" to all eligibility groups, its impact is not neutral. It shifts financial and health risks onto the communities already most disadvantaged, undermining Minnesota's "One Minnesota Plan" equity goals.

Retroactive coverage costs less than **1% of overall Medicaid spending**, but in State Fiscal Year 2024, it prevented almost $130 million in unpaid medical bills.[15] Under P.L. 119-21, this protection would shrink to an estimated $93 million, **a loss of nearly $37 million, or about a 29% reduction in retroactive payments**, exposing disadvantaged Minnesotans and safety-net providers to debt and financial strain.[15]

Children (including 19- and 20-year-olds), families, and pregnant people:*

- Minnesotan children, families, and pregnant people will experience funding for their retroactive coverage dropping from about $43.8 million a year to $38.4 million, about a 12% reduction, leaving more well-child visits, immunizations, and urgent care episodes at risk of going unpaid.[15] **Low-income**

Minnesotan children and families will pay an estimated $5.4 million more out of pocket a year from these Medicaid cuts.

- Children and families rely heavily on Medicaid for preventive and primary care, and disruptions in retroactive coverage increase risks of undetected illness and disease and uncovered hospitalizations for acute episodes like asthma or diabetes complications.

***Note:** Minnesota treats 19-20-year-olds as children for Medicaid eligibility so this age group will be subject to the 2-month retroactive coverage limitation rather than the 1-month limitation for expansion adults.*

Adults without dependent children (ages 21-64):

- Minnesotan adults without dependent children face the steepest increase in health care costs from the retroactive reimbursement cuts, with funding for them dropping from $65.9 million a year to an estimated $38 million, about a 42% reduction in payments, putting them at the greatest financial risk.[15] **Adults without dependent children will pay an estimated $27.9 million more a year out of pocket from these Medicaid cuts.**
- Adults without dependent children face the steepest reduction in coverage (from 3 months to 1 month), exposing them to higher risk of medical debt.

Seniors and people with disabilities:

- Minnesota seniors and people with disabilities will experience an increase in health care costs with retroactive reimbursement funding for them decreasing from $20.1 million a year to $16.2 million, about a 19% reduction, despite research demonstrating this population needing the most continuous care.[15] **Seniors and people with disabilities will pay an estimated $3.9 million more a year out of pocket from these Medicaid cuts.**
- These Minnesotans often require long-term services and supports. Even with a 2-month retroactive coverage window, uncovered hospitalizations or nursing home bills can threaten both family finances and provider solvency.

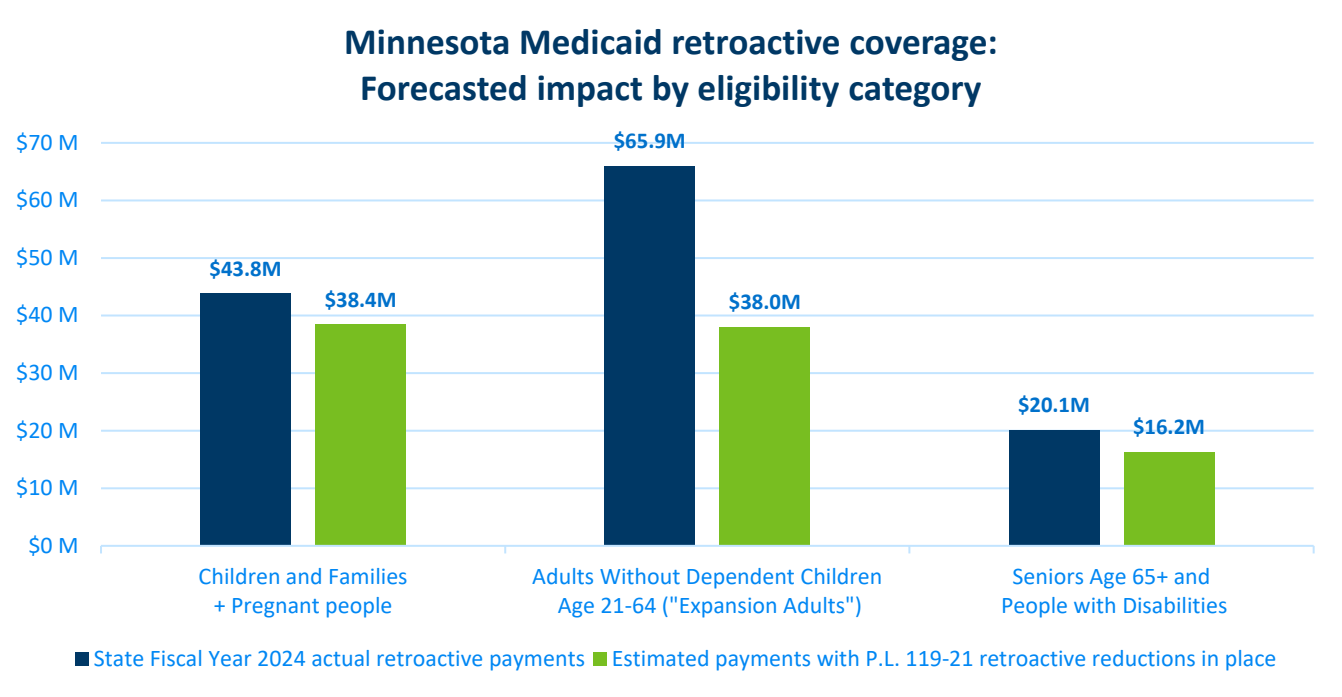

Table 2. Data and fiscal analysis were provided by the Minnesota Department of Human Services Reports and Forecasts Division and extracted May 14, 2025. This analysis shows the actual retroactive payments made for different eligibility groups in State Fiscal Year 2024, and the estimated retroactive payments for each eligibility group if the reduced retroactive coverage in P.L. 119-21 had been in place.

Disparities in health or social outcomes

Disparities in health and social outcomes overlap in many communities, even those with shared experiences of disadvantage like Medicaid-eligible community members. It is therefore important to maintain a focus on communities that have been disproportionately impacted by systemic inequities while implementing Medicaid legislation. This section highlights key demographic and socioeconomic groups; however, the Office of the Medicaid Medical Director recognizes that these categories are not all-inclusive. The intersectionality of identities such as race, ethnicity, gender, disability, sexuality, and socioeconomic status can compound challenges and shape unique experiences of relative disadvantage and advantage. This analysis will be an evolving effort, and the Office of the Medicaid Medical Director remains committed to continuously refining this approach by incorporating feedback from community members and partners and integrating new data sources to better capture the complexities of these disparities over time.

Communities with inequitable chronic disease and preventable hospitalizations

Hospitalization rates reflect a disproportionate burden of preventable chronic disease on racial and ethnic minority groups.[16] American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and Black Minnesotans bear the heaviest — and earliest — burdens of preventable hospitalizations. Because racial and ethnic minority groups already experience higher chronic disease burdens and preventable hospitalizations, cuts to retroactive coverage will amplify inequities in medical debt burden by leaving sudden hospitalizations uncovered.

American Indian Minnesotans experience rates of Type 2 diabetes 6 times higher than white Minnesotans and are 182% more likely to die from it, with correspondingly elevated rates of preventable hospitalizations and mortality.[17] Their diabetes hospitalization rate is approximately 765 per 100,000 people, which is about 7 times the rate of white Minnesotans (about 109 per 100,000 people).[16] Among adults ages 45-64, American Indian Minnesotans are hospitalized for heart disease at a rate of 2,547 per 100,000 people, which is 4 times higher than white Minnesotans (620 per 100,000 people).[16]

Native Hawaiian/Pacific Islander Minnesotans from 2019 to 2023 have the highest diabetes-related hospitalization rate at approximately 765 per 100,000 people, which is nearly 9 times higher than white Minnesotans (about 109 per 100,000 people).[16]

Black Minnesotans also experience significantly higher rates of preventable hospitalizations and chronic disease burdens compared to white Minnesotans, including a diabetes-related hospitalization rate of 343 per 100,000 people (about 3 times the rate of white Minnesotans) and a heart disease hospitalization rate of 1,074 per 100,000 people (more than 2 times higher than white Minnesotans at 620 per 100,000 people), producing high rates of preventable admissions in large metro counties.[16]

Rural counties. Many rural counties experience higher rates of hospitalization related to chronic conditions compared to the statewide rate.[16] Mahnomen and Beltrami experience the highest diabetes-related hospitalization rates.[16]

Bottom line: The greatest harm concentrates among American Indian, Native Hawaiian/Pacific Islander, rural and Black Minnesotans, making retroactive coverage protections especially consequential for these communities.

Why this matters. These disparities are rooted in discriminatory practices in health care and systemic barriers, such as poverty, coverage gaps, provider shortages, limited broadband access, and lack of culturally responsive care.[18–20] Under the shortened retroactive coverage periods in P.L. 119-21, any hospitalization or urgent medical episode that occurs before enrollment is more likely to remain uncovered. This places American Indian, Black, Native Hawaiian/Pacific Islander, multiracial, and rural Minnesotans, who already bear the highest rates of preventable hospitalizations and chronic disease burden, at elevated risk of both medical debt and worse health outcomes, while also increasing uncompensated care burdens on safety-net providers.

Greater Minnesota (rural) communities

Throughout the Minnesota Department of Health's Statewide Health Assessment, "Greater Minnesota" is used when referring to the geography outside of the seven-county metro area. People may not identify with the term rural, and rural data categories are complex and can vary between data sources.[21] This analysis takes a similar approach while recognizing that specific data sources cited may still use the term "rural." Minnesotans in Greater Minnesota experience higher rates of Medicaid coverage, travel longer distances to access medical care, and face more severe provider shortages compared to residents of the state's metropolitan areas.[18,21] These disparities highlight how geography intersects with inequities in access to health services in Minnesota.

Over the past decade, many of the hospitals in Greater Minnesota have experienced service declines due to closures, consolidations, or the loss of key services.[18] Rural hospitals, especially critical-access hospitals, already operate on narrow margins. When residents experience sudden hospitalizations (from conditions such as diabetic ketoacidosis, asthma attacks, or heart failure) and delays in Medicaid enrollment, local hospitals disproportionately absorb the costs.[7,18,21] Retroactive coverage historically provided a backstop, allowing providers to bill for care delivered in the three months before a Medicaid application. Cutting this window to one or two months under P.L. 119-21 reduces that safety net, increasing uncompensated care and further destabilizing rural facilities that are often the only source of care within a large geographic region.

Medicaid coverage has a disproportionately critical impact in Greater Minnesota. Counties like Mahnomen, overlapping with the White Earth Nation, illustrate the intersection of rurality and Tribal sovereignty: Nearly half of residents have Medicaid coverage.[1] This means any disruption in coverage, including shortened retroactive eligibility, translates into direct risks for both residents and providers.

Rural communities experience heightened barriers to reliable high-speed internet or broadband services. Data from 2023 shows that about 162,000 Minnesota households still lacked access to basic broadband, 229,000 more were underserved, and about 245,000 low-income households were at risk of losing affordable internet.[12] When broadband access is weak, delayed online applications are more likely, leaving hospital stays uncovered and pushing families into medical debt.

Why this matters. Rural areas already face shortages of clinicians, higher travel distances, limited broadband, and higher poverty rates, which are all factors that make timely Medicaid enrollment more challenging.[18,21] By shortening the retroactive window, P.L. 119-21 places rural patients at higher risk of uncovered bills and places rural providers at higher risk of financial strain. This could accelerate rural hospital closures or service cuts, reducing access even further. The impact will be most severe in counties with large American Indian populations and in small-town Minnesota, where Medicaid plays a disproportionate role in sustaining community health systems.[1,18]

Tribal and Urban Indian communities

American Indian communities in Minnesota experience some of the most severe inequities in health.[22] Based on state data, American Indian Minnesotans are more likely to face chronic disease, substance use disorders, and housing instability, and have a lower life expectancy compared with the state average.[22,23]

Preventable hospitalizations are elevated for Tribal communities at particular risk of compounded inequities, such as high poverty, high chronic disease burden, and weak digital infrastructure.[22,23] Beyond physical health, social drivers that compound inequities include unstable housing, limited broadband, discrimination in health care settings, and difficulty navigating administrative systems.[23] These barriers can reduce timely access to Medicaid enrollment and coverage continuity, leaving Tribal members at disproportionate risk from shortened retroactive coverage.

Why this matters. Unlike other provisions under P.L. 119-21, a member's Tribal affiliation will not exempt them from the law's shortened retroactive coverage periods once it goes into effect. Retroactive coverage has historically provided a critical safety net for Tribal members who face delays in applying due to systemic and

geographic barriers. Shortening the coverage period from three months to one or two months under P.L. 119-21 means hospitalizations or urgent care episodes that occur just before enrollment are less likely to be reimbursed. This is particularly harmful for Tribal communities, where preventable chronic disease hospitalization rates and rates of Medicaid coverage are high (such as Mahnomen County overlapping with White Earth Nation).[1,16] Uncompensated care burdens will also fall disproportionately on Indian Health Services clinics, Tribal health programs, and safety-net providers serving Tribal and Urban Indian populations. These facilities already face underfunding and workforce shortages.[23] Without retroactive protection, financial strain will deepen, threatening service availability in these regions.

Black communities

Minnesota has one of the highest income inequality gaps between Black and white residents, with Black individuals earning 71 cents on the dollar compared to white Minnesotans.[24,25] Homeownership rates are significantly lower for Black households (24%) compared to white households (77%).[25] Black Minnesotans have reported food insecurity at more than double the rate of white Minnesotans.[25]

Black Minnesotans experience significantly higher rates of preventable hospitalizations and chronic disease burdens compared to white Minnesotans.[16,25] The 2021 Minnesota Health Access Survey found that 39% of Black Minnesotans report unfair treatment by health care providers, compared with just 9% of white Minnesotans.[26] Black Medicaid enrollees experience lower rates of optimal care for chronic conditions compared to other racial groups.[25] There is a strong need for disaggregated data to understand differences in health care access and outcomes U.S.-born and immigrant Black communities.[25] Without this level of detail, policies and interventions risk overlooking the unique challenges, needs, and strengths within diverse Black communities in Minnesota.

Why this matters. Health inequities and social conditions, including racism, have persisted for centuries and continue to shape outcomes for Black communities in Minnesota. The shortened retroactive coverage period under P.L. 119-21 intensifies these disparities. For Black families, who already face some of the steepest income inequality gaps in the state, losing access to months of retroactive coverage means higher risks of medical debt, delayed care, and uncompensated costs for essential services. Because Black Minnesotans are more likely to encounter income fluctuations, gaps in coverage, and systemic barriers in accessing care, shortened retroactive eligibility will disproportionately expose them to periods without financial protection. This compounds existing inequities, such as higher maternal mortality, lower rates of homeownership, and higher reported difficulty in accessing care. The shortened coverage period threatens to deepen structural disadvantages for Black communities.

Communities experiencing unstable housing

A widely used measure of housing-instability risk shows that around 550,000 Minnesotans pay more than 30% of their income on housing (i.e., are “cost burdened”).[28] Median rent in Minnesota increased by 8% from 2023 to 2024, making housing costs harder to manage.[29] The number of people experiencing homelessness on a single night in Minnesota has increased by 16% from 2022 to 2024.[30] Based on the 2023 U.S. Department of Housing and Urban Development's Point-in-Time count, at least 8,393 Minnesotans experience homelessness on a given night, though this is an undercount since it excludes those “doubling up” with family or friends.[30]

The racial inequities are also stark: In 2023, the American Indians in Minnesota were 28 time more likely to experience homelessness than non-Hispanic white residents, while Black Minnesotans were 13 times more likely.[30]

Why this matters. People experiencing homelessness or housing instability face delays in Medicaid enrollment due to unstable addresses, limited internet access, and documentation barriers. Under the shortened retroactive coverage periods, urgent hospitalizations that occur before enrollment are more likely to remain uncovered. This places Minnesotans who may be close to or are already experiencing homelessness at heightened financial and health risk, while safety-net providers helping them absorb more uncompensated care.

LGBTQ+ communities

Equity in health care means more than just access to services; it requires care that is respectful, free of bias, and responsive to the lived experiences of all Minnesotans. Yet, the Minnesota Health Access Survey (2021) finds that 50% of transgender Minnesotans reported unfair treatment by health care providers, compared with just 9% of white Minnesotans and 12% of cisgender men.[31] A 2021 survey of LGBTQ+ Minnesotans found that 27% of respondents had forgone needed medical care in the past year due to cost and 18% of respondents reported having a provider refuse to care for them because they were LGBTQ+.[32] These inequities reflect systemic racism, bias, and discrimination in the health care system that directly undermine trust and health outcomes. Minnesota's "One Minnesota Plan" recognizes these inequities and has put forth a goal to reduce unfair treatment among Black, trans, and nonbinary Minnesotans. [31] Achieving this goal is critical for restoring trust, improving preventive care use, and addressing longstanding disparities in chronic disease and mortality.

Why this matters. Shortening the retroactive Medicaid coverage period magnifies the risks for groups already reporting high levels of discrimination in care. Without adequate retroactive protection, hospitalizations or urgent care episodes that occur just before enrollment are more likely to be uncovered, leading to medical debt and further erosion of trust in health systems.

Immigrant communities, including those with limited English proficiency

Minnesota is home to roughly 495,000 foreign-born residents (about 9% of the state), with large Somali and Mexican communities and many families with mixed immigration statuses. Minnesota's immigrant population is diverse, including African communities, such as Somali (42,503), Ethiopian (22,453), Liberian (12,446), and Kenyan (11,181) immigrants; Asian communities, such as Hmong (29,034), Indian (30,632), Karen/Burmese (12,480), Korean (13,727), and Vietnamese (16,078) immigrants; and Latin American communities, including Mexican (59,137), Ecuadorian (6,703), Guatemalan (6,619), and Salvadoran (7,302) immigrants. Other large groups include Chinese (17,746), Filipino (9,936), Russian (8,107), German (6,811), and Canadian (11,179).[33]

Immigrants contribute to the social and economic fabric of rural, suburban and urban areas across Minnesota, yet face distinctive health coverage barriers tied to immigration status, language access, and affordability.[19,20,33,34] Noncitizens are far more likely to be uninsured than citizens; in a 2023 national study, 18% of lawfully present adult immigrants reported being uninsured, compared to 8% of U.S.-born citizens.[35] Minnesotans from Laos, Mexico, and Somalia experience lower rates of preventive care and chronic disease management compared to statewide averages.[19]

Our health care system's inability to consistently support people with limited English proficiency impacts access to health insurance and care, creating barriers that lead to delayed enrollment, lower use of preventive services, and increased reliance on costly and avoidable emergency care.[20] People with limited English proficiency, no matter if English is their primary language or not, face challenges in understanding and communicating health information, which contributes to gaps in health insurance coverage and poorer health outcomes.[20,35] In Minnesota, where Spanish is the most common non-English language followed by language families containing Somali, Oromo, Hmong, and Vietnamese, these challenges are notably pressing.[33] Because people of color are more likely to have limited English proficiency than white individuals, language-related barriers also contribute to persistent racial and ethnic health disparities.

Why this matters. Starting October 2026, P.L. 211-19 narrows the types of lawfully present immigration statuses eligible for Medicaid, leaving many previously eligible groups without coverage.[4] For those who remain eligible, shortened retroactive coverage windows mean that urgent hospitalizations or emergency care just before filing an application are less likely to be reimbursed, especially when language, paperwork, or fear-related barriers delay enrollment. Those who lose eligibility will rely more heavily on Emergency Medical Assistance, which provides limited coverage for emergent conditions, leaving ongoing care, prescriptions, and pre-application bills unpaid, resulting in greater medical debt for immigrant households and higher uncompensated care burdens for safety-net providers, particularly in areas where immigrant communities make up a large share of the population. These outcomes not only deepen existing inequities but also undermine Minnesota's broader "One Minnesota Plan" equity goals of reducing racial and geographic disparities in access to care.

Communities with disabilities

About 12% of Minnesotans live with a disability, representing more than 700,000 people across age groups and regions.[36] Many rely on Medicaid for core benefits and cost-sharing support, especially older adults and those with significant functional limitations. In Minnesota, individuals who qualify for Medicaid due to a disability or who are aged 65 or older represent roughly 15% of all Medicaid enrollees, yet they account for about 60 % of the program's spending because of their greater care needs and extensive long-term services and supports; many of these beneficiaries are also dually eligible for Medicare and Medicaid.[1]

People with disabilities frequently encounter additional paperwork, documentation, and accessibility barriers (e.g., assistive-technology accommodations, plain-language forms, interpreter services, and timely signatures from caregivers/guardians). Digital barriers and rural distances can compound delays. In Minnesota's Medicaid program, 29% of enrollees live in strictly rural areas and 14% report three or more chronic conditions, underscoring how complexity and geography intersect with disability to slow timely filing.[36,37]

Why this matters. P.L. 119-21 reduces Medicaid retroactive coverage to two months for seniors and people who qualify for Medicaid based on a disability. When an emergency room visit or inpatient hospital stay occurs just outside that window because an application was delayed by accessibility or documentation challenges, bills are less likely to be covered, even if the person is found eligible once the application is processed. A shorter retroactive window increases the risk that pre-application hospitalizations or home-health visits fall outside coverage, shifting costs to individuals and caregivers or to providers who furnish care upfront.[9]

Safety-net hospitals and long-term care facilities serving high proportions of disabled and older Minnesotans face more uncompensated care when back-billing is no longer possible for the third month before application. This is especially destabilizing for safety-net hospitals in rural areas where margins are thin.[9,18]

Medicaid's evidence of impact

A strong body of evidence demonstrates Medicaid's central role in advancing health and financial stability. Coverage through Medicaid reduces hospitalizations for preventable conditions, improves management of chronic illnesses such as diabetes and asthma, and lowers both infant and maternal mortality by ensuring access to preventive and continuous care.[38,39] Research also shows that Medicaid expansion to adults without dependent children reduces medical debt and improves credit outcomes, underscoring that coverage protects household financial well-being as well as health.[40] Importantly, Medicaid expansion has been consistently associated with narrowing disparities in access to care across race, ethnicity, income, education, insurance type, and employment status, helping to close long-standing health equity gaps.[41]

When retroactive coverage is shortened, the buffer against life instability, paperwork delays, or sudden illness is weakened. Families who would have had prior hospitalizations or urgent care visits covered during a three-month retroactive window may now face only one to two months of protection, depending on their eligibility category. This puts more Minnesotans one illness or one accident away from financial ruin. It creates long-term financial consequences: unresolved medical debt is associated with worse access to future care, stress, and broader economic instability. [42,43]

In Minnesota, Medicaid enrollees and community partners have consistently prioritized timely Medicaid enrollment, culturally responsive application and enrollment support, and continuity of coverage as essential to closing gaps.[44] Community engagement repeatedly affirms that enrollment delays cause inequitable access and disproportionately affect people with disabilities, American Indian families, immigrant households, and rural residents, all of whom face structural barriers to timely application filing. Retroactive coverage was designed to mitigate these inequities by covering care during the waiting period. Its rollback compounds the harm, particularly for groups whose trust has historically and contemporarily been undermined by our health systems.

Alignment with priorities

The "One Minnesota Plan" includes goals to reduce the percentage of Black Minnesotans and trans and nonbinary Minnesotans reporting unfair treatment from providers by 2027.[31] The "One Minnesota Plan" also sets a measurable goal to reduce homelessness by 16% by 2027, with an explicit focus on reducing racial inequities in who experiences homelessness. Strengthening housing stability is both a health equity and Medicaid equity priority.[30] Limiting retroactive eligibility runs counter to these equity goals by increasing financial exposure and care interruptions for groups that already report higher rates of unfair treatment and barriers to timely care. Shorter retroactive coverage increases the consequence of any pre-application delay and raises the importance of rapid, in-language application assistance.

Because immigrants are part of Minnesota's workforce and community fabric in every region, tightening eligibility and shortening retroactive protection can widen inequities in preventive and chronic care, strain

family finances, and erode trust —this is counter to the State's "One Minnesota Plan" equity goals. Targeted application and enrollment support, language-concordant assistance, and state options (e.g., preserving coverage with state funds where permissible) are therefore critical mitigation strategies.

People with disabilities already face higher health needs, structural barriers to coverage, and risks of discrimination in the health system. By shortening retroactive coverage to two months, P.L. 119-21 increases the likelihood that urgent care and essential supports go unpaid. This threatens the independence of Minnesotans with disabilities, strains family caregivers, and destabilizes the system of home- and community- based services providers, which is counter to the State's "One Minnesota Plan" equity goals of inclusion, independence, and dignity for all residents.

The bottom line. Across domains such as health care access, housing stability, geographic access, and disability equity, the shortened retroactive coverage under P.L. 119-21 is **misaligned** with the "One Minnesota Plan." Instead of closing gaps, it risks widening them, undermining the State's measurable goals in health and human services and destabilizing the providers who anchor care in rural, urban, Tribal, gender-diverse, disabled, and immigrant communities alike.

Alternatives and adequacy

- There are no comprehensive alternative coverage options available for people who lose Medicaid retroactive coverage protections. **Hospital financial assistance and charity care programs** offer discounts on unpaid medical bills for eligible uninsured patients. While they ease financial burdens for individuals, they increase uncompensated care for providers and have limited funds.
- **MinnesotaCare**, the State's Basic Health Program, covers people up to 200% of the federal poverty level, or $30,120 a year for a single person in 2025. However, the program requires monthly premiums and **does not cover retroactive medical bills incurred before enrollment.**
- **Marketplace coverage** through MNsure **does not address retroactive medical bills incurred before enrollment** and remains out of reach for many low-income families as premiums and deductibles can be cost-prohibitive even with subsidies.

The bottom line. None of these options replicate Medicaid's role as a safety net or its ability to cover sudden medical costs incurred before enrollment.

Interacting provisions that increase risk

Several other provisions in P.L. 119-21 increase reporting requirements or reduce eligibility, which makes the shorter retroactive period more consequential.

Six-month renewals for expansion adults (Sec. 71107). The requirement for more frequent eligibility redeterminations, which takes effect January 1, 2027, increases opportunities for disenrollment from administrative burden or paperwork barriers. When eligible people lose coverage and have to reapply, they face gaps for services received before their new application date.[4]

Work reporting requirements for expansion adults (Sec. 71119). New reporting obligations, which take effect January 1, 2027, unless an extension is granted, are projected to drive significant coverage losses. When individuals lose coverage and later regain it, services received before reapplication remain uncovered.[4]

Restriction of eligibility for some lawfully present immigrants (Sec. 71109). Beginning October 1, 2026, a narrowed definition of "qualified" immigrant will exclude more individuals from Medicaid. Families in mixed-status households may experience delays and increased out-of-pocket costs. In addition, changes to Emergency Medical Assistance will reduce retroactive protections for urgent care, raising uncompensated care burdens.[4]

Long-term implications

Without intervention, reducing retroactive coverage is likely to widen existing disparities.

For enrollees. Populations already at higher risk of chronic conditions, such as American Indian, Black, and Native Hawaiian/Pacific Islander Minnesotans, face greater exposure to medical debt. Medical debt can snowball into other financial crises, impacting the ability to pay for basic necessities or secure loans for a more stable future, such as loans for housing, cars, or an education. This furthers inequities in generational wealth. Families with children, people with disabilities, and seniors may delay care due to fear of uncovered costs.[9,16]

For providers. Safety-net providers, especially rural critical-access hospitals, federally qualified health centers, and long-term care facilities, will face rising uncompensated care burdens. Minnesota's rural hospitals already operate on narrow margins; additional revenue loss may trigger service reductions or closures, further decreasing access in high-need communities.[7,18]

For the system. Minnesota's broader equity goals under the "One Minnesota Plan" to reduce health disparities, strengthen housing stability, and ensure dignity for people with disabilities get undermined by a federal policy change that places greater risk on disadvantaged families and providers.[31]

Implementation strategy and policy considerations for State and partners

To mitigate the projected disproportionate harms of retroactive Medicaid coverage reductions under P.L. 119-21, Minnesota can pursue a combination of State administrative actions, legislative policy, community engagement, and targeted investments to help uphold its commitment to health equity.

Monitoring change

A comprehensive approach, including partners across the health system will be needed to understand the full scope of retroactive coverage changes and their impacts across diverse communities.

Before implementation

To assess potential impacts and inform outreach to affected patients and providers, Minnesota should develop a monitoring system focused on retroactive claims activity. Specifically, the system should track:

- Claims submitted in the second and third months prior to application for adults without dependent children.
- Claims submitted in the third month before application for all other eligibility groups and for claims.

The data should be publicly reported on an annual basis and include breakdowns by:

- Eligibility category
- Race and ethnicity
- Metro versus rural county of residence
- Facility type

After implementation

Ongoing monitoring will be essential once reductions in retroactive coverage are implemented and should include:

- Monitoring trends in total retroactive claims submitted and denied
- Disaggregated data by eligibility category, race and ethnicity, and metro vs. rural county of residence
- Measures of health care utilization and health outcomes among affected populations
- System-level impacts, such as increases in uncompensated care, provider financial strain, and hospital closures or reductions in available services
- Surveys of Minnesotans affected by retroactive coverage changes to understand their experiences, including barriers to care, financial hardship, and impacts on health and well-being.

Communication and implementation burdens

Shortened retroactive coverage will increase the urgency of timely Medicaid applications and renewals, magnifying burdens for both enrollees and the system. To effectively inform impacted individuals about changes to retroactive Medicaid coverage, coordinated efforts will be needed to provide clear, plain-language explanations detailing who is affected and how to access help from MNsure navigators, clinic financial assistance staff, and other trusted resources. Communication must be multilingual, culturally appropriate, and delivered through multiple channels, including mail, phone, digital platforms, and in-person outreach. Successful outreach and navigation support will require collaboration among the Department of Human Services, counties, managed care organizations, and trusted community-based organizations, such as schools, faith groups, clinics, and cultural liaisons. Without investment in this coordinated effort, there is a high risk of confusion among affected individuals, delays in application, and increased medical debt.

Shortened retroactive periods introduce significant uncertainty and financial strain for providers, especially for safety-net, rural, and long-term care facilities. Providers will need clear, timely communications to manage the transition, including detailed guidance on new billing timelines, dedicated technical assistance, and regular updates from the Department of Human Services.

Counties and Tribes that process Medicaid applications will require clear, consistent, and proactive communication from the Department of Human Services to effectively implement changes related to reduced

retroactive coverage, including training on eligibility rules, system changes, and how to explain the shortened retroactive period to applicants in a clear and accessible way. Standardized messaging, FAQs, and scripts should be provided to ensure consistency across counties and reduce confusion for both county staff and Medicaid enrollees.

Implementation strategies and policy options matrix: Mitigating equity harms of reduced retroactive coverage

The implementation strategies and policy options offered in this report are grounded in the insights, concerns, and priorities shared by community members and health equity subject matter experts through ongoing engagement. They are not intended to be prescriptive or exhaustive; rather, they serve as guidance for agency leaders, policymakers, and legislators to consider as Minnesota moves forward with implementation of P.L. 119-21. These recommendations highlight opportunities to minimize disparate impacts and to strengthen equity within the systems and communities most affected. Their purpose is to illuminate community-identified pathways toward more just and responsive policy and to support informed decision-making that aligns with the State's commitments to equity, inclusion, and community partnership.

Strategy	Department of Human Services/State administration	Department of Human Services + Community partnerships	State legislative
Phased & equitable rollout	Prepare IT systems; assess equity impacts, communicate early and often	Partner with counties, Tribes, managed care organizations, providers, and navigators for outreach capacity-building	Appropriate funding to support equitable implementation
Monitor & report equity outcomes	Create dashboard tracking retroactive claims, denials, uncompensated care, demographics	Invest in community engagement efforts to capture and share ongoing community feedback Monitor health care utilization and health outcomes among affected populations Monitor system-level impacts such as increases in uncompensated care, provider financial strain, hospital closures, or	

Strategy	Department of Human Services/State administration	Department of Human Services + Community partnerships	State legislative
		reductions in available services	
Align with State equity priorities	Integrate with "One Minnesota Plan" and Medicaid modernization (reduce churn, digital equity)		
Targeted outreach & navigation	Provide support and training to counties, navigators, and community partners	Fund community-based organizations, Tribes, and culturally specific providers for navigation, translation, cultural brokering	
Promote timely application filing strategies		Partner with navigators, assisters, and local providers to support timely application filing	
Support safety-net providers	Technical assistance on revenue cycle and timely application filing		Allocate resources to offset uncompensated care for critical-access hospitals & Federally Qualified Health Centers

Table summary

- **Department of Human Services/State administrative actions** focus on operational readiness, and equity monitoring.
- **Department of Human Services + community partnerships** emphasize outreach, culturally responsive navigation, and capturing lived experiences.
- **Legislative actions** focus on appropriations, statutory authority, and long-term structural fixes (information technology (IT) systems, safety-net stabilization).

Action steps for Medicaid enrollees

To protect health coverage for themselves, their families, and their communities, it's important for Medicaid enrollees to stay informed and take action. Enrollees should follow these steps to avoid interruptions in their coverage and ensure they continue receiving the care they need.

- **Keep your contact information up to date.** Make sure your contact information is current so important time-sensitive material about your coverage gets to you.
- **Renew your coverage on a timely basis.** You must renew your coverage periodically. The Minnesota Department of Human Services has created this tool for you to look up your renewal date. Renew your coverage on time to prevent gaps in coverage. If you lose Medical Assistance, you will be subject to the reduced retroactive coverage once you reapply and are determined eligible.
- **Don't wait until an emergency to apply.** If you or your family members are not enrolled in Medical Assistance but meet the eligibility criteria, apply now. It's important to get insurance in place to avoid bills for emergency health care that may no longer get covered retroactively. Learn eligibility criteria.
- **Stay informed.** The Minnesota Department of Human Services will be your trusted guide.
    - Visit mn.gov/dhs/federalchanges, and sign up on the webpage for email updates.
    - Follow the Department of Human Services on social media:
        - Facebook
        - X
        - Instagram
    - Watch your mail and text messages for information from the Minnesota Department of Human Services.

References

1. Minnesota Department of Human Services. Medicaid Matters: By the Numbers. Minnesota Department of Human Services. Accessed September 9, 2025. https://mn.gov/dhs/medicaid-matters/by-the-numbers/

2. SHADAC. SHADAC analysis of the 2022-2023 American Community Survey (ACS) Public Use Microdata Sample (PUMS) files.

3. MN Department of Human Services. Medicaid Matters: 10 Ways Minnesota Medicaid Matters to You. Published online 2023. https://mn.gov/dhs/medicaid-matters/10-ways/

4. Rep. Arrington JC [R T 19. Text - H.R.1 - 119th Congress (2025-2026): One Big Beautiful Bill Act. July 4, 2025. Accessed July 29, 2025. https://www.congress.gov/bill/119th-congress/house-bill/1/text

5. Arrington-Guthrie-Letter-Medicaid-hr1. Accessed September 2, 2025. https://www.cbo.gov/system/files/2025-06/Arrington-Guthrie-Letter-Medicaid.pdf

6. MN Department of Human Services. Historic Cuts to Health Care Will Impact Every Minnesotan. Published online 2025. https://mn.gov/dhs/assets/historic-cuts-to-health-care-will-impact-every-minnesotan_tcm1053-699475.pdf

7. American Hospital Association. Rural hospitals at risk: Cuts to Medicaid would further threaten access [Fact sheet]. Published online March 13, 2025. https://www.aha.org/fact-sheets/2025-06-13-rural-hospitals-risk-cuts-medicaid-would-further-threaten-access

8. Courtot B, Blavin F, Allen EH, Arnos D. *Section 1115 Waivers of Retroactive Medicaid Eligibility: Lack of Evidence Raises Flags and Warrants Caution*. Urban Institute; 2021. Accessed October 22, 2025. https://www.urban.org/research/publication/section-1115-waivers-retroactive-medicaid-eligibility

9. Medicaid and CHIP Payment and Access Commission (MACPAC). Medicaid Retroactive Eligibility: Changes under Section 1115 Waivers. Published online 2019. https://www.macpac.gov/wp-content/uploads/2019/08/Medicaid-Retroactive-Eligibility-Changes-under-Section-1115-Waivers.pdf

10. Medicaid Unwinding: Why Retroactive Coverage is not the Answer to Procedural Disenrollments as Some Claim. Center For Children and Families. June 22, 2023. Accessed October 24, 2025. https://ccf.georgetown.edu/2023/06/22/medicaid-unwinding-why-retroactive-coverage-is-not-the-panacea-to-procedural-disenrollments-as-some-claim/

11. Rosenbaum S. Demonstrations to Limit Retroactive Eligibility in Medicaid Lack Evidence and Threaten Access to Care. doi:10.26099/fan3-4369

12. Bekele T. *Minnesota Governor's Task Force on Broadband*.; 2024. https://mn.gov/deed/assets/2024-broadband-task-force-report_tcm1045-664936.pdf

13. *In the United States Court of Appeals for the District of Columbia Circuit*. 20, 161-170 (2025). Accessed October 24, 2025. https://www.cambridge.org/core/product/identifier/S0020782900032551/type/journal_article

14. MN Department of Human Services. Summary of Medicaid Provisions in the 2025 Federal Reconciliation Bill. Published online August 2025. https://mn.gov/dhs/assets/summary-of-medicaid-provisions-in-the-2025-federal-reconciliation-bill_tcm1053-685438.pdf

15. Minnesota DHS Reports and Forecasts Division. *Medical Assistance A Fiscal Analysis of Reducing Retroactive MA Eligibility*.; 2025.

16. MN Department of Health. Heart Disease, Stroke and Diabetes Hospitalizations in Minnesota. Published online April 2025. https://www.health.state.mn.us/diseases/chronic/cdhospdata.html

17. Johnson-Jennings M, Punjabi A, Paul K, Jones J, Jennings D. Little Earth Strong: A Community-Level, Culturally Appropriate Diabetes Prevention Pilot Targeting Urban American Indians. Published online 2022. https://pmc.ncbi.nlm.nih.gov/articles/PMC8781635/

18. MN Department of Health. Rural Health Care in Minnesota: Data Highlights. Published online November 2021. https://www.health.state.mn.us/data/economics/docs/ruralhealthcb2021.pdf

19. Donovan J, Xiong M, Adams L, Cinqueonce L. *Health Care in Minnesota: Summary Report*. MN Community Measurement; 2025. https://mncmsecure.org/website/Reports/Community%20Reports/Summary%20Report/2023MY_Summary%20Report_QDC.pdf

20. Ponce NA, Hays RD, Cunningham WE. Linguistic Disparities in Health Care Access and Health Status Among Older Adults. *J Gen Intern Med*. 2006;21(7):786-791. doi:10.1111/j.1525-1497.2006.00491.x

21. Healthy Minnesota Partnership and Minnesota Department of Health. *Minnesota Statewide Health Assessment*.; 2024. https://www.health.state.mn.us/communities/practice/healthymnpartnership/sha.pdf

22. Minnesota Department of Health. *Office of American Indian Health 2025 Report to the Minnesota Legislature*.; 2025. Accessed October 23, 2025. https://www.lrl.mn.gov/docs/2025/mandated/250148.pdf

23. Chomilo N, Lightfield T, Grauman L, et al. Pathways to Racial Equity in Medicaid: Improving the Health and Opportunity of American Indians in Minnesota. Published online 2024. https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8209C-ENG

24. U.S. Department of Health and Human Services. *2018 National Healthcare Quality and Disparities Report*.; 2019. https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2018qdr.pdf

25. Chomilo NT, Diaz-Rivero D, Garrett E, Hultgren J, Nelson J. Building Racial Equity into the Walls of Minnesota Medicaid: A Focus on U.S.-born Black Minnesotans. Published online February 2022. https://www.lrl.mn.gov/docs/2022/other/220230.pdf

26. Office of Governor Tim Walz & Lt. Governor Peggy Flanagan. Health Disparities. One Minnesota Plan. Accessed July 29, 2025. https://mn.gov/mmb/one-mn-plan/measurable-goals/health-disparities.jsp

27. Minnesota Department of Health. Maternal Morbidity and Mortality. Published online August 1, 2019. https://www.health.state.mn.us/docs/communities/titlev/maternalmorbmort.pdf

28. Minnesota Housing Project. Key Facts on Housing 2022. 2022. Accessed October 23, 2025. https://mhponline.org/wp-content/uploads/MHP_KeyFacts_2022.pdf

29. Minnesota Housing Partnership. 2024 State of the State's Housing Profile with Key Minnesota Findings and Trends. Accessed October 23, 2025. https://mhponline.org/wp-content/uploads/2024_State_Profile_Findings_FINAL.pdf

30. State of Minnesota-Minnesota Management Budget Office. One Minnesota Plan: Measurable Goals: Housing Stability. Published online 2021. https://mn.gov/mmb/one-mn-plan/measurable-goals/housing-stability.jsp

31. State of Minnesota-Minnesota Management Budget Office. One Minnesota Plan: Measurable Goals: Health Disparities. Published online 2021. https://mn.gov/mmb/one-mn-plan/measurable-goals/health-disparities.jsp

32. Rainbow Health. *2021-Voices-of-Health-Full-Report*.; 2021. Accessed October 23, 2025. https://rainbowhealth.org/wp-content/uploads/2023/03/2021-Voices-of-Health-Full-Report.pdf

33. By immigrant group | MN Compass. Accessed October 24, 2025. https://www.mncompass.org/topics/demographics/immigration

34. Haldar S, Artiga S, Rudowitz R, Damico A. Unwinding of the PHE: Maintaining Medicaid for People with Limited English Proficiency. KFF. March 3, 2022. Accessed October 24, 2025. https://www.kff.org/medicaid/unwinding-of-the-phe-maintaining-medicaid-for-people-with-limited-english-proficiency/

35. Pillai D, Artiga S, Hamel L, et al. Health and Health Care Experiences of Immigrants: The 2023 KFF/LA Times Survey of Immigrants. KFF. September 17, 2023. Accessed October 24, 2025. https://www.kff.org/racial-equity-and-health-policy/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants/

36. By disability status | MN Compass. Accessed October 24, 2025. https://www.mncompass.org/topics/demographics/disability

37. KFF. Medicaid in Minnesota. May 2025. Accessed October 24, 2025. https://files.kff.org/attachment/fact-sheet-medicaid-state-MN

38. Guth M, Garfield R, Rudowitz R. The effects of Medicaid expansion under the ACA: Updated findings from a literature review. Published online March 2020. https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/

39. Breslin E, Heaphy D, Dreyfus T, Lambertino A, Schiff J. *Advancing Health Justice Using Medicaid Data: Key Lessons from Minnesota for the Nation*. AcademyHealth; 2021. Accessed September 10, 2025. https://academyhealth.org/sites/default/files/publication/%5Bfield_date%3Acustom%3AY%5D-%5Bfield_date%3Acustom%3Am%5D/advancinghealthjusticeusingmedicaiddata_jan2021.pdf

40. kffmadelineg. The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020. KFF. March 17, 2020. Accessed September 2, 2025. https://www.kff.org/affordable-care-act/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/

41. Corallo B, Garfield R, Tolbert J, Rudowitz R. Medicaid Enrollment Churn and Implications for Continuous Coverage Policies. KFF. December 14, 2021. Accessed September 10, 2025. https://www.kff.org/medicaid/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/

42. Han X, Hu X, Zheng Z, Shi KS, Yabroff KR. Associations of Medical Debt With Health Status, Premature Death, and Mortality in the US. *JAMA Netw Open*. 2024;7(3):e2354766. doi:10.1001/jamanetworkopen.2023.54766

43. Winger A, Claxton G, Rae M, Rakshit S, Damico A. How Financially Vulnerable are People with Medical Debt? KFF. February 12, 2024. Accessed October 24, 2025. https://www.kff.org/health-costs/how-financially-vulnerable-are-people-with-medical-debt/

44. Minnesota Department of Human Services. *2025 Minnesota Medicaid Equity Forum*.; 2025.