DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, MD 21244-1850

State Demonstrations Group

August 4, 2026

John Connolly
Deputy Commissioner and State Medicaid Director
Minnesota Department of Human Services
540 Cedar Street
St. Paul, MN 55167-0983

Dear Deputy Commissioner Connolly:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the Program Integrity Plan for Minesota's section 1115(a) demonstration, "Minnesota Substance Use Disorder System Reform" (Project Number 11-W-00320/5). We have determined that the plan is consistent with the requirements outlined in the special terms and conditions (STCs), specifically STC 3.16, and are, therefore, approving it. A copy of the approved plan is enclosed.

States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid and Children's Health Insurance Program (CHIP) funds and must fully comply with all applicable Medicaid and CHIP statutes and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in title XIX and title XXI of the Social Security Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity including processes to identify, investigate, and refer suspected fraud, and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid and CHIP services, including referrals to law enforcement when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a plan detailing the state's systems and safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

If you have any questions, please contact your CMS project officer, Jonathan Morancy, at Jonathan.Morancy@cms.hhs.gov.

Sincerely,

Angela D. Garner -S

Digitally signed by Angela D. Garner -S
Date: 2026.08.04 07:48:13 -04'00'

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc: Courtenay Savage, State Lead, Medicaid and CHIP Operations Group

Program Integrity Plan

Substance Use Disorder System Reform
Section 1115 Demonstration Waiver No. 11-W-00320/5

Introduction

This is Minnesota's Program Integrity Plan for the Substance Use Disorder (SUD) System Reform demonstration waiver (No. 11-W-00320/5) authorized under section 1115 of the Social Security Act. This plan is being submitted to the Centers for Medicare and Medicaid Services (CMS) by the Minnesota Department of Human Services (Department) as required by item 3.16 of the waiver's Special Terms and Conditions (STCs) dated March 27, 2026.

Background

CMS approved Minnesota's SUD waiver for the period of April 1, 2026 through March 31, 2031. The waiver is managed by the Department and operates under section 1115(a)(2) of the Social Security Act. This Medicaid demonstration authority provides federal funds for Medicaid beneficiaries receiving residential SUD treatment in facilities defined as Institutions for Mental Diseases (IMDs) under federal Medicaid law.

The waiver was developed in 2018 and 2019 in response to the growing public health crisis of opioid use disorders (OUD) and SUD in Minnesota and supports broader reforms of SUD service delivery. Participation in the waiver requires states to implement nationally recognized evidence-based treatment guidelines. It also requires participating states to provide a comprehensive set of SUD treatment services under the Medicaid program, including outpatient, intensive outpatient, medication assisted treatment (MAT), residential inpatient and medically supervised withdrawal management.

This demonstration provides critical support for Minnesotans receiving SUD treatment services that would otherwise be ineligible for federal Medicaid reimbursement. Over half of Minnesota's residential treatment beds are in IMDs, and continued receipt of Medicaid funding for residential SUD treatment facilities is critical to the state's larger reform efforts to address the opioid crisis.

State Program Integrity Plan

The STCs require a state-developed program integrity plan that addresses oversight in all approved Section 1115 demonstrations in Minnesota. Few of the state's eligible populations and covered services are authorized under Section 1115 waivers, and the program integrity measures described below are not limited to populations or

services covered under those waivers. This document is not a comprehensive detailed list of all program integrity activities employed by the Department. The activities described below are largely enhancements developed over the last year and some recently authorized by the legislature in response to vulnerabilities identified by the state. What follows is a description of internal controls, processes, and activities to enhance the state's efforts to prevent, detect, and address fraud, waste and abuse. This Program Integrity Plan aligns with Minnesota's Corrective Action Plan, which was approved by CMS on March 19, 2026 (see attachment A) and includes new measures authorized by the legislature earlier this year.

Oversight of Provider Screening and Enrollment

The Department enrolls providers who meet the professional certification and licensure requirements according to applicable state and federal laws and regulations specific to the services provided. After an individual provider or organization meets professional certification and licensure requirements, they can apply to be an enrolled Minnesota Health Care Programs (MHCP) provider by submitting the application materials required for enrollment. Providers access all service enrollment information, including enrollment forms, on the Department's website.

The Department implemented a moratorium on the issuance of new licenses for providers of certain services effective January 1, 2026. The state will not accept any new license applications or requests to add additional services to existing licenses. There are a limited number of exceptions to the moratorium that will be reviewed on a case-by-case basis. The moratorium will allow the Department to more effectively use available resources to monitor service providers for compliance with licensing standards and program integrity measures.

The Department submitted requests to CMS for temporary enrollment moratoria for certain services determined to be high-risk services on January 23, 2026. CMS approved the Department's request, and a 6-month enrollment moratoria across these services took effect on January 27, 2026. For more information, see https://mn.gov/dhs/media/news/?id=1053-719094.

The Department has also been reviewing its provider enrollment records and terminating inactive providers. In October 2025, the Department terminated 761 providers due to inactivity. Between October 2025 and March 2026, the Department terminated an additional 18,109 providers that had not billed Medicaid in the past year. Disenrollment at this scale frees up resources for other high-priority program integrity work.

The Department is currently in the process of revalidating all providers of high-risk services. This effort requires an in-person site visit, fingerprint background study for individuals with a controlling interest in the provider organization, and verification of provider credentials for approximately 5,800 providers. The Department will complete this revalidation process by May 31, 2026, and deactivate those providers who are not responsive or are deemed out of compliance.

Oversight of Service Utilization

Minnesota uses prior authorization as a condition of payment throughout the Medicaid program to ensure services are medically necessary. Currently, Minnesota has prior authorization requirements on more than 3,400

codes in its Medicaid Management Information System (MMIS). The use of prior authorizations or service level authorizations is a tool identified in the state's Program Integrity Playbook where the Department identifies a need for increased oversight and authorization. The Department is reviewing its use of prior authorization and will repeat this process every two years. The focus of this review is to identify opportunities to use prior authorization and ensure the process does not hinder access to needed services.

The state employs electronic visit verification for several services with a personal care component. The Minnesota State Legislature directed the Department to expand the use of this tool to additional high-risk services in both 2027 and 2028.

Pre- and Post-Payment Reviews

The Department began implementation of a pre-payment review process in January 2026 for the services identified as high-risk. The Department is working with a vendor to audit fee-for service billing using advanced analytics to identify risks before making payments, including developing and implementing flags for suspicious claims that will then be reviewed by Department staff before either paying the claim or withholding payment. The purpose of this process is to ensure ineligible claims are not paid and that fraud is identified and prevented before claims adjudication.

The Department receives reports from the vendor every two weeks. These reports flag claims for potential fraud, waste, and abuse. Summaries of these reports are shared with Department leadership. The report summaries include information about the follow-up being conducted, such as referrals to the Office of Inspector General, provider follow-up, and investigations based on suspicious trends and patterns.

The Department uses geo-fencing related to submission of claims from the MN-ITS portal (the State's billing system for providers enrolled in Minnesota Health Care Programs) to assure all claims submitted came from the United States. In order for a claim to be paid, the MN-ITS user must be located inside the United States.

The Department's Medicaid Provider Audits and Investigations Unit (MPAI) is responsible for post-payment review of provider claims paid through MMIS. Providers and claims are selected for review based on data analysis, complaints, and referrals. This includes identifying and investigating possible Medicaid fraud. The Department utilizes risk monitoring dashboards to prioritize investigations. The Department is leveraging reporting tools and developing a formal review process to monitor warrant cycles and expedite follow up on providers who exhibit patterns of significant billing abnormalities.

Earlier this month, the Minnesota State Legislature appropriated funds for an additional vendor contract to support post-payment review of managed care claims. The state's contracted managed care plans serve over 80 percent of the state's 1.2 million Medicaid enrollees, and this effort will support existing functions and activities to reduce the incidence of fraud and abuse.

Review of Payment Methodologies and Rate Setting

The Department periodically reviews payment rates and presents recommended updates to the legislature for consideration. Since 2020, the Department has reviewed payment rates for mental health and SUD services,

home and community-based services, and targeted case management services. The Minnesota Legislature has adopted many of the Department's recommendations.

Utilization Controls

The Department is taking measures to improve fraud detection through enhanced expenditure and utilization tracking. In addition to the actions described above, in October 2025, the Department began a formal surveillance and utilization review of services using an internal predictive analytics dashboard. This enhanced review process enables the Department's policy teams to monitor and evaluate fiscal performance and program integrity, including:

- Total expenditures compared to budget and trends over time.
- Number of active providers delivering services.
- Overall service utilization rates.
- Average cost per person receiving services.
- Distribution of spending per person receiving services.

Earlier this month, the Minnesota State Legislature adopted new billing limits for several home and community-based services identified as high risk by the Department.

Audits/Investigations and Referrals to Law Enforcement

The Department has strong partnerships with state and federal law enforcement agencies and refers all cases of suspected Medicaid provider fraud to the Minnesota Attorney General's Office as described in the approved state plan. This is particularly important when there is evidence of shared ownership and broad networks of connected individuals working together to commit fraud. Law enforcement has broader authority and tools to investigate the nuances of these networks. The Medicaid Fraud Control Unit (MFCU) at the Minnesota Attorney General's Office and the United States Attorney's Office have the power to charge crimes, including those with wide criminal enterprise connections. The Department's Inspector General meets weekly with the heads of the Minnesota Bureau of Criminal Apprehension (BCA) and the Attorney General's Office to collaborate on issues related to preventing and prosecuting Medicaid fraud. The Office of Inspector General (OIG) staff meet on a bi-monthly basis with MFCU staff to discuss trends, patterns, and specific cases of suspected fraud. OIG staff are also in frequent communication with the Federal Bureau of Investigation (FBI) and U.S. Department of Health and Human Services OIG agents regarding program trends, specific providers, requests for information, and subpoenas, and has met with the U.S. Attorney's Office several times during the past year. To quickly detect, identify, investigate, and take action against fraudulent networks, the Department and law enforcement each play an important role: The Department has the authority to swiftly stop payments when a credible allegation of fraud is determined, while law enforcement has the authority to pursue criminal charges and convictions.

The Department also collaborates with and refers information about suspected fraud to partners across state and law enforcement agencies and the Office of Legislative Auditor (OLA). The Department recently launched a new data sharing application intended to provide up to date information on sanctions and to facilitate the

sharing of data across agencies and the OLA who need the information to conduct their own investigations and make connections between programs.

In 2025, the Department issued over 500 payment withholds to providers where it was determined there was a credible allegation of fraud. Since 2020, the Department has conducted over 3000 investigations, referred over 500 cases to law enforcement, and identified more than $50 million for recovery.

Evidence of the state's program integrity actions, including law enforcement referrals and provider sanctions, is available on the Department's website: https://mn.gov/dhs/program-integrity.

Other Program Integrity Measures

Program Assessments

The Department completed Program Assessments for the 13 high-risk services in April 2026 and will complete the remaining Medicaid covered services by August 2026. These Program Assessments are aimed at clarifying responsibility, governance and oversight of risks and vulnerabilities in our programs. They are meant to be actively maintained, reviewed and updated. The purpose of these documents is to assist our agency in achieving a more proactive approach to program integrity and enhance our culture of compliance within the Department. The Program Assessments will be ongoing and revised at least annually, and include:

- Compliance gap analysis;
- Risk assessment and mitigation plan;
- Utilization review and monitoring;
- Randomized provider evaluations;
- Documented oversight, monitoring and reporting procedures; and
- Clear accountability within roles and escalation (RACI matrices).

In the fourth quarter of 2025, the Department developed and deployed analytic dashboards for 14 high-risk service types that apply standardized risk metrics and descriptive indicators to identify potentially concerning provider and billing behavior. These dashboards are advisory in nature and support risk identification, prioritization, and human review. These dashboards support:

- Peer-group utilization comparisons by service type, geography, and provider characteristics.
- Identification of billing outliers and sudden billing spikes.
- Flagging of frequency and behavioral patterns that may warrant further review.

Provider Training and Education

Providers of waiver services are required to complete the Home and Community-Based Services Waiver and Alternative Care Provider Training 101 during enrollment. Personal care service providers have 30 days after active enrollment to complete required training on billing. Waiver providers have six months after active enrollment to complete the required training.

Training includes a detailed review of provider requirements, with emphasis on:

- Federal and state exclusion lists
- Provider participation requirements and violations of the provider agreement
- Provider abuse
- Program Integrity Oversight Division (PIOD) functions
- Health service documentation standards
- Record-keeping requirements and investigative processes
- Monetary recovery and sanctioning procedures
- Crimes related to Minnesota Health Care Program (MCHP) participation
- Access to care requirements
- Payment Error Rate Measurement (PERM) expectations and error-reduction strategies
- Billing requirements
- How to report fraud

During the 2025 legislative session, the Legislature mandated an expansion of training requirements to additional service areas, including Recovery Community Organizations (RCOs) and recuperative care providers, to promote greater consistency, accountability, and oversight across Minnesota's Medicaid program.

Training and Education for Department Employees

The Department is requiring additional training for staff regarding their obligation to identify and report Medicaid fraud and ensure proper documentation for all state and federal expenditures. All employees must complete this required training by the end of 2026.

Participant Training and Education

The Department launched a communications campaign to educate the public, including people receiving services, their families, service providers, counties and Tribal human service agencies about program integrity in Minnesota Medicaid programs. The Department's program integrity website (https://mn.gov/dhs/program-integrity/) includes news, fact checks, educational information about what is fraud, waste and abuse and how the public can report concerns, and ongoing strategies and actions the Department takes to combat fraud, waste and abuse. The website went live on December 2, 2025. Additional information and resources regarding program integrity are available online:

- Minnesota Department of Human Services Licensing Lookup: https://licensinglookup.dhs.state.mn.us
- Pre-payment review Frequently Asked Questions: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/provider-news/pre-payment-review-faq.jsp
- Minnesota Office of Inspector General: https://mn.gov/dhs/general-public/office-of-inspector-general/report-fraud/

The Department also disseminated information to county and Tribal human service agencies to share with case managers, people receiving services, and families about the program integrity website, verification of provider licenses, pre-payment review, and how to report fraud, waste and abuse.

Analysis of State-Identified Deficiencies in the Current Processes

Minnesota's approved Program Integrity Corrective Action Plan with CMS details the program integrity concerns that have been identified in the state, and the actions and timeline for remediation (see attachment A).

Data Analytics Plan

The Department is strengthening Medicaid program integrity through the expanded use of advanced analytics, automated indicators, and data-driven dashboards to support risk-based oversight across provider enrollment, claims payment, and post-payment review. The Department's analytic approach is designed as a closed-loop oversight framework in which risk indicators inform operational action, outcomes are measured and validated, and analytic thresholds and processes are continuously refined. This structure ensures analytics functions as integrated program integrity controls rather than standalone tools.

Current capabilities are limited to rules-based and descriptive analytics and do not include automated decision-making or machine learning models. All current and planned analytic enhancements are subject to legislative authority and approval by CMS through the Advanced Planning Document (APD) process.

Processes to Address Program Integrity Concerns

The Department uses existing governance structures to address identified program integrity concerns. These groups are comprised of executive and director level staff with the authority to prioritize work and direct resources where they are needed. Where necessary, the Department may escalate issues to the Governor's Office who can redeploy resources from other agencies or issue contracts to address emergent issues.

Remediation of Deficiencies

Minnesota's approved Corrective Action Plan with CMS details the actions and timeline for remediating identified program integrity concerns (see Attachment A). The Department will use existing governance structures to address any additional deficiencies identified by the state or CMS in a manner consistent with state and federal requirements.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Deputy Administrator
Washington, DC 20201

March 19, 2026

John Connolly
State Medicaid Director
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, MN 55155

Dear Director Connolly:

I write on behalf of the Centers for Medicare & Medicaid Services (CMS) regarding Minnesota's Medicaid Corrective Action Plan (CAP) and the State's ongoing implementation efforts.

Corrective Action Plan

As Administrator Dr. Mehmet Oz noted in his January 6, 2026, letter to Minnesota, CMS identified several deficiencies in the CAP submitted by the State on December 31, 2025. In that letter, CMS included a timeline of milestones for the State to achieve over the coming months to guide future discussions between our teams and ensure those deficiencies were addressed in a mutually agreed-upon manner. These milestones provided the structure needed to direct CMS's work with Minnesota, including regular meetings, weekly data reporting metrics, and CMS's onsite visit in January 2026. CMS followed up on January 12, 2026, with an email outlining the specific CAP deficiencies and the revisions the State would need to make to submit a sufficient CAP. That communication also identified CMS's expectations of deliverables due at specified milestones.

Minnesota submitted a revised CAP on January 30, 2026, that addressed the deficiencies CMS identified to the State on January 12, 2026. Therefore, the CAP is approved.

Implementation of the Corrective Action Plan to Achieve Compliance

Thus far, Minnesota has met both the February 1, 2026 and March 1, 2026 milestones described in the approved CAP. CMS expects the State to continue implementing the revised CAP with CMS support until completion; meet with CMS to discuss milestone updates and any issues that arise, as needed; and continue submitting weekly data reporting metrics as previously agreed upon.

In particular, Minnesota is taking on one of the revised CAP's most critical initiatives—conducting off-cycle provider revalidations of the high-risk provider types—and we request continuing status updates regarding the revalidation actions described in the approved CAP through the initiative's completion. Specifically, the State committed to completing the revalidation process by May 31, 2026. Given that Minnesota stated this work "will require tremendous additional, professional human capacity beyond what it currently has available for

provider revalidation work," we request confirmation that Minnesota still anticipates meeting that May 31, 2026, milestone. In addition, we request information regarding when CMS can expect a report on the revalidation process outcomes and analysis.

CMS also requests a new meeting cadence aligned with the milestones described in the approved CAP. Specifically, CMS proposes holding meetings as each milestone date arrives at which the State would present status updates, including evidence of the actions the State has taken. Should Minnesota anticipate difficulty meeting a milestone, please raise the issue with CMS as soon as possible, along with a proposed solution and a revised timeline. Should Minnesota need to make revisions to the CAP, such as altering action items, please inform CMS in advance so that both parties can reach agreement before the State submits an updated CAP reflecting those changes.

Regarding Minnesota's pending appeal from the January 6, 2026, letter about a potential withholding action related to issues of significant program integrity noncompliance, CMS requests that the hearing be stayed pending complete implementation of the approved CAP, as successful completion would moot the appeal. The HHS Office of the General Counsel will contact the Office of the Minnesota Attorney General regarding filing a motion for a stay.

CMS remains committed to working collaboratively with Minnesota and looks forward to continued progress protecting critical Medicaid taxpayer dollars and the beneficiaries we serve. Please do not hesitate to contact CMS with any questions or concerns.

Sincerely,

Kimberly Brandt
Deputy Administrator and Chief Operating Officer

Minnesota Department of Human Services
Elmer L. Andersen Building
John Connolly, Ph.D., M.S.Ed.
Deputy Commissioner and Minnesota Medicaid Director
Post Office Box 64998
St. Paul, Minnesota 55164-0998

January 30, 2026

Kim Brandt, Chief Operating Officer and Deputy Administrator
Daniel Brillman, Deputy Administrator
Centers for Medicare & Medicaid Services (CMS)
7500 Security Blvd
Baltimore, MD 21244-1850

Subject: Corrective Action Plan for Program Integrity Update

Deputy Administrators Brandt and Brillman:

The Minnesota Department of Human Services (DHS) is submitting this revised, comprehensive corrective action plan on behalf of Governor Tim Walz in response to the letter from Administrator Oz dated January 6, 2026. This revised corrective action plan proposes additional program integrity actions and identifies timeframes for implementation and performance metrics to evaluate each action where appropriate. As part of our ongoing commitment to fighting and preventing fraud, the Department hosted in-person meetings with CMS staff on January 21 and 22 and seeks good faith collaboration to finalize and begin implementing the corrective action plan.

The Department has taken additional actions beyond the items listed in Governor Walz's Executive Order 25-10, including the following actions described in our first reply to your letter:

- In October 2024, DHS began a top-to-bottom, on-site audit process of all autism service providers enrolled in the State of Minnesota. This work prompted an aggressive Early Intensive Developmental and Behavioral Intervention (EIDBI) program integrity legislative package, and additional anti-fraud requests to shift oversight from relying on a tip-based investigative model, to a proactive model to stop fraud on the front-end.

- Early in 2025, DHS changed the designation of EIDBI and Housing Stabilization Services (HSS) to high-risk to provide additional program integrity tools, including unannounced on-site visits.
- DHS requested assistance from CMS on August 1, 2025, to take the unprecedented action to terminate the agency's Housing Stabilization Services (HSS) benefit to protect the fiscal integrity of Minnesota's Medicaid program. We appreciate the support we received from your team during that process, which resulted in CMS approval to shutter the HSS program at the end of October.
- During HSS termination discussions, CMS suggested that DHS disenroll inactive health care providers to further safeguard against fraudulent billing. DHS immediately acted on that suggestion, and to-date has disenrolled almost 6,000 inactive providers since October 2025. That work continues with a review of an additional 13,000 providers, many of which will receive termination notices by January 30.
- DHS has acted more aggressively to withhold payments over the last year. In 2025, DHS issued over 500 payment withholds to providers where DHS determined there was a credible allegation of fraud.
    - Since the Executive Order was signed, DHS has implemented 134 payment withholds, issued ten monetary recoveries, and two suspensions relative to the fourteen high risk services.

In his January 6 letter, Administrator Oz indicated that the CAP did not demonstrate the state's ability to understand ownership or corporate structure of providers or detail how the state will work with law enforcement to ensure that Medicaid funds are not used to support criminal entities. DHS agrees that understanding current ownership structures of providers is a key component to preventing and detecting fraud and necessarily works with its law enforcement partners to investigate and expose criminal networks to ensure Medicaid is not supporting these entities.

To accomplish this, DHS maintains ownership information on all enrolled and licensed providers, which is required by state and federal law. DHS further requires that providers update ownership information should it change. DHS verifies this ownership information at initial validation and routinely through revalidation and licensing reviews (for those services that require licensure). When DHS determines a provider has failed to disclose or lied about their ownership, it sanctions the provider, up to termination. DHS is revalidating all providers in the 13 high-risk services to verify ownership information.

Any full investigation into a provider always involves an ownership analysis to determine whether the owners are affiliated with *other* Medicaid providers. As the fraud schemes have become more sophisticated, DHS has found networks of affiliated providers working together across multiple programs in an attempt to defraud the system at multiple points. When DHS makes those connections, it takes actions against all affiliated providers supported by the evidence. In fact, DHS has expanded authority to take actions against Medicaid providers whose affiliated entities and individuals are found to be committing fraud against other publicly funded programs as well – Minnesota Statutes, section 245.095 was proposed by DHS, passing initially in 2019, and has continued to be enhanced as an effective tool to mitigate the opportunities of bad actors to commit fraud across state and federal public programs, including Medicaid.

DHS has strong partnerships with state and federal law enforcement agencies and refers all cases of suspected Medicaid provider fraud to the Minnesota Attorney General's Office as described in the approved state plan. This is particularly important when there is evidence of shared ownership and broad networks of connected individuals working together to commit fraud. Law enforcement has broader authority and tools to investigate the nuances of these networks. MFCU and the United States Attorney's Office have the power to charge crimes, including those with wide criminal enterprise connections. The DHS Inspector General meets weekly with the heads of the Minnesota Bureau of Criminal Apprehension (BCA) and the Attorney General's Office's (AGO) Medicaid Fraud Control Unit (MFCU) to collaborate on issues related to preventing and prosecuting Medicaid fraud. Office of Inspector General staff meets on a bi-monthly basis with MFCU staff to discuss trends, patterns, and specific cases of suspected fraud. Office of Inspector General staff are also in frequent communication with the FBI and HHS-OIG agents regarding program trends, specific providers, requests for information, and subpoenas, and has met with the U.S. Attorney's Office several times during the past year. To quickly detect, identify, investigate, and take action against fraudulent networks, DHS and law enforcement each play an important role: DHS has the authority to swiftly stop payments when a credible allegation of fraud is determined, while law enforcement has the authority to pursue criminal charges and convictions.

DHS also collaborates with and refers information about suspected fraud to partners across state and law enforcement agencies and the Office of Legislative Auditor (OLA). DHS recently launched a new data sharing application intended to provide up to date information on sanctions and to facilitate the sharing of data across agencies and the OLA who need the information to conduct their own investigations and make connections between programs.

Evidence of the state's program integrity actions, including law enforcement referrals and provider sanctions, is available on the Department's website: https://mn.gov/dhs/program-integrity.

Also in the January 6 letter, Administrator Oz indicates that the state did not commit to specific enforcement actions, recovery targets, referral thresholds, or timelines for resolving identified overpayments or fraud. It is unclear in this statement what specific component of DHS' program integrity work Administrator Oz is referencing, but there are protocols in place to address suspected fraud, waste, or abuse at multiple points of the billing, enrollment, and investigative process. For example, the prepayment review process includes guidelines on when a claim requires further review before payment or denial as well as guidelines on when a case should be referred for a deeper investigation by the Office of Inspector General. The Office of Inspector General in turn has policies in for implementing sanctions and pursuing administrative action against provides including monetary recoveries, payment withholds, suspensions, and terminations. Through its policies and actions, especially over the past year and a half, DHS has demonstrated its commitment to taking swift and strong enforcement actions. For example, under Minnesota law, DHS is required to cut off funding to people and businesses when an investigation uncovers "credible allegations of fraud." DHS has a strong commitment to imposing sanctions against providers, including cutting off funding and making law enforcement referrals, when we uncover evidence of fraud. While the prepayment review process has just begun, DHS is already demonstrating its commitment to enforcement action through the detailed review and denial of claims.

Through this Corrective Action Plan, DHS seeks to address items CMS found deficient in the previous CAP, dated December 31, 2025, and to take further steps to assure that Minnesota's Medicaid program is a leader in program integrity. We believe we are building on a strong foundation and will adapt our program to respond to the novel fraud schemes employed by criminals across the country.

Program Integrity Playbook

The Administrator's letter of January 6th requested the state include additional items from the state's Program Integrity Playbook. The section that follows includes the detail and specificity requested in Dr. Oz's letter. The Administrator's correspondence also requested that the state's CAP include timelines and performance metrics for the measures included in the state's submission of December 31, 2025. The discussion that follows the items from the Program Integrity Playbook includes this detail for actions in the state's earlier submission as well as some new program integrity measures.

Program Assessments

- **February 1, 2026**
  - DHS will commence Program Assessments for the 13 high-risk services and all other Medicaid covered services.
  - These assessments will be ongoing and revised at least annually (summary attached).
  - Program Assessments include:
    - a compliance gap analysis,
    - risk assessment and mitigation plan,
    - utilization review and monitoring,
    - randomized provider evaluations,
    - documented oversight, monitoring and reporting procedures, and
    - clear accountability within roles and escalation (RACI matrices)
  - DHS will use guidance from the GAO Fraud Risk Management Report.
- **March 1, 2026**
  - DHS to send CMS a revised MN PI Playbook, using similar metrics as those applied to the CAP.
- **April 1, 2026**
  - DHS will complete Program Assessments for the 13 high risk services. At this time, DHS plans to use internal resources for this activity, including redeployed staff, but will explore the assistance of a vendor for the assessments, as appropriate.
  - DHS will develop a governance structure for program oversight and compliance to review risks, mitigation strategies and results of provider evaluations for adequacy and oversight.
- **August 1, 2026**
  - DHS will complete Program Assessments for all covered services.
  - DHS program integrity governance body will prepare and submit a report to CMS with governance and oversight activities.

These Program Assessments are aimed at clarifying responsibility, governance and oversight of risks and vulnerabilities in our programs. These are meant to be actively maintained, reviewed and updated. The purpose of these documents is to assist our

agency in achieving a more proactive approach to program integrity and enhance our culture of compliance within DHS.

Prior Authorization

Minnesota uses prior authorization as a condition of payment throughout the Medicaid program to ensure services are medically necessary and that the service is the least costly alternative. To date, Minnesota has prior authorization requirements on more than 3,400 codes. The use of prior authorizations or service level authorizations is identified in the PI playbook where policy areas identify a need for increased oversight and authorization.

- **March 31, 2026**
    - To enhance consistency and transparency, DHS will review prior authorization requirements for existing services and repeat this analysis every two years. DHS will also implement a quarterly audit of the prior authorizations approved and denied by the contractor to assess whether updates need to be made to prior authorization policies.
      MN state law has numerous limitations in the use of prior authorization. During the 2026 legislative session, DHS will work with the legislature to remove restrictions against using prior authorization in its Medicaid program.

Provider Training and Education

Minnesota currently requires Steps for Success training for personal care providers prior to enrollment. All owners and managing employees must complete this training before enrolling as a Medicaid provider. This training delivers updated resources and guidance designed to reinforce compliance expectations and strengthen program integrity standards for personal care service providers.

During the 2025 legislative session, the Legislature mandated an expansion of these training requirements to additional service areas—including Recovery Community Organizations (RCOs) and recuperative care providers—to promote greater consistency, accountability, and oversight across Minnesota's Medicaid program.

- **January 1, 2027**
    - All owners and managing employees for RCOs, and Recuperative Care providers will have to complete the training prior to enrollment and every 3 years thereafter.
- **January 1, 2028**

  - All RCO and Recuperative Care providers who were enrolled prior to this date must complete the training no later than January 1, 2028 and every 3 years thereafter.

Workshop and training materials cover key program integrity and compliance topics, including:

- Program Integrity and Oversight (PIO)
- Medicaid Fraud Control Unit (MFCU) – 1-hour dedicated session
- Fraud prevention practices, including site visits and oversight activities
- Provider responsibilities and compliance obligations
- Use of the Provider Manual and adherence to guidelines prior to claims submission

Waiver providers are also required to complete the Home and Community-Based Services (HCBS) Waiver and Alternative Care Provider Training 101 during enrollment. Personal care service providers have 30 days after active enrollment to complete a required billing session. Waiver providers have 6 months after active enrollment to complete a required billing session.

- **March 1, 2026**
  - Provider enrollment staff monitor compliance with these trainings in our system and will develop reports to track compliance.
- **August 1, 2026**
  - Additional training modules are currently available to providers but are not mandatory. Our provider trainers will make these trainings available on demand.

Training includes a detailed review of provider requirements, with emphasis on:

- Federal and state exclusion lists
- Provider participation requirements and violations of the provider agreement
- Provider abuse
- Program Integrity Oversight Division (PIOD) functions
- Health service documentation standards
- Record-keeping requirements and investigative processes
- Monetary recovery and sanctioning procedures
- Crimes related to MHCP participation
- Access to care requirements

- PERM expectations and error-reduction strategies
- Billing requirements
- How to report fraud

DHS Employee Training and Education

The Department will provide and require additional training for staff regarding their obligations to identify and report Medicaid fraud and to ensure proper documentation for all state and federal expenditures. All employees will complete this new required training by the end of 2026.

- **March 1, 2026**
    - DHS's OIG and Minnesota's Medicaid Fraud Control Unit will provide an annual staff training session on identifying and reporting Medicaid fraud, waste and abuse. This training is expected to improve communication, provide guidance, and support enhanced program integrity activities. An outline of this training is available and attached to this letter. It will also cover an overview of how to identify and report provider abuse (attached). These trainings will be required for staff annually, administered through their online training profiles. The Department will develop additional content by May 1, 2026, regarding required documentation to support all federal expenditures. This includes all state plan and waiver authorities, eligibility records, provider files, and accounting data.
- **Ongoing**
    - DHS will identify appropriate staff to attend relevant Medicaid Integrity Institute (MII) trainings.

Surveillance and Utilization Review

The Department is taking measures to improve fraud detection through enhanced expenditure and utilization tracking. In October 2025, DHS began a formal surveillance and utilization review of services using an internal predictive analytics dashboard. This enhanced review process enables DHS policy teams to monitor and evaluate fiscal performance and program integrity, including:

- Total expenditures compared to budget and trends over time
- Number of active providers delivering services
- Overall service utilization rates
- Average cost per recipient

- Distribution of spending per recipient

The dashboard identifies statistical outliers and identifies potential risk to guide further analysis and determine whether billing patterns are explainable.

- **Monthly**
  - Data are updated monthly, and policy teams document their review of billing patterns, noting whether identified anomalies are reasonable and explainable based on available data and contextual factors. When billing patterns are not explainable, referrals will be made to the Program Integrity Oversight (PIO) team for further investigation.
- **Semi-Annual**
  - Oversight of the monthly data reviews are conducted semi-annually and are incorporated into the program assessments, referenced in the Program Integrity Playbook. Review of data informs the provider review selection and risk identification and mitigation activities. These data are monitored monthly. Outliers are reported to the program integrity governance and oversight structure quarterly to assure that escalation was effective, and related risks are documented and mitigated.

Managed Care Oversight

Last year, DHS conducted post payment claims review of managed care organization (MCO) payments for Housing Stabilization Services (HSS) and Personal Care Assistant (PCA) claims. The review resulted in multiple MCO breach of contract notices, new corrective action plans, and the identification of over $4 million in payments for services in excess of the contractual allowed amounts.

The Department is continuing its review of MCO claims with CMS' Unified Program Integrity (UPIC) contractor. Post-payment review of MCO claims as part of these investigations are overseen by CMS and resulted in completed recoveries in the amount of over $135,000 in calendar year 2025 and about $36,000 in calendar year 2024. Only completed recoveries and closed cases are included, and 2026 recoveries are expected to be in the millions of dollars once the recoveries are collected and the cases are completed.

In January 2026, DHS engaged an outside vendor through a limited, temporary contract to increase review of post-payment MCO claims. DHS will work with the legislature to secure

permanent funding and dedicated staff to oversee the contract and to continue expansion of MCO post-payment claims reviews and recoveries.

DHS will pursue the following changes to managed care oversight via contract amendment or legislative action where necessary:

- Require MCOs to conduct prepayment review of their claims to match the requirements set by DHS fee-for-service.
- Secure funding for the State to implement a vendor contract that would conduct broad-scoping ongoing post-payment review of all MCO encounter claims and State staff to support this effort.
- Require increased transparency by publishing MCO program integrity actions and outcomes with the State information on the DHS program integrity website.
- Require MCOs to implement all claims edits and policies that are implemented by DHS fee-for-service and provide a State position to coordinate and ensure claims edits and policy limits are consistent between MCOs and fee-for-service.
- Expanding Electronic Visit Verification to include additional HCBS services with a personal care component.
- **January 1, 2026**
  DHS updated 2026 MCO contract language to allow DHS to sanction an MCO with repeated contract breaches that occurred for the same incident type.
- **July 1, 2026**
  DHS to negotiate mid-year MCO contract amendments, to be effective July 1, 2026, that would:
    - Shorten the current 6-month timeframe MCOs are afforded to recover overpayments from providers when the State initiates investigations and identifies Medicaid overpayments.
    - Increase the percentage of State identified overpayments DHS is allowed to recover to 100% from the MCO, including incidents in which the MCO is unable to collect from the provider.
    - Require MCOs to implement payment suspensions and make associated criminal referrals when a provider refuses to grant access to their records.
    - Change current MCO reporting structure for required monthly adverse action reports and case referrals to the State for better tracking and monitoring by the State.
    - Increase the required number of SIU investigative staff based on MCO enrollment
    - Require MCOs to conduct investigative provider site visits

Enrollment Moratoria for Providers in 13 High-Risk Service Areas

Late last year DHS took several actions to temporarily pause enrollment of new providers across many of the identified high-risk services. First, the Department implemented an enrollment moratorium for Early Intensive Developmental and Behavioral Intervention (EIDBI) services in November 2025 and an HCBS licensure moratorium that began January 1, 2026. A licensure moratorium on one additional service will take effect on February 1, 2026. These actions effectively stop enrollment of new providers across 7 of the remaining 13 high-risk services identified by DHS's risk assessment.

The December 5th correspondence from CMS included a recommendation that the state also enact enrollment moratoriums for all high-risk services. The Department concurred with this recommendation submitting requests for temporary enrollment moratoria for all services (except EIDBI) on January 23, 2026. CMS approved the state's requests, and a 6-month enrollment moratoria across the remaining 12 services took effect on January 27, 2026.

DHS will take the following actions on or before the specified date during the temporary moratorium period:

- **March 1, 2026**
    - MN to share a report with CMS that details their moratoria exit strategy and how they will address any access to care issues that arise as a result of the moratoria
- **April 27, 2026**
    - Submit an access to care analysis demonstrating continued access to services subject to an enrollment moratorium
- **June 27, 2026**
    - Provide a written request to extend enrollment moratoria where appropriate

In recognition of the statutory requirement to ensure enrollees have access to covered services, the Department will make exceptions to moratoria based on verifiable access to care needs. Moratoria may be extended or lifted at the end of the initial 6-month period based on the state's assessment of risk and progress implementing corrective actions.

Off-Cycle Revalidation for Providers in 13 High-Risk Service Areas

In its December 5th letter, CMS strongly recommended DHS complete this action as soon as practicable. We agree with CMS's direction and have initiated an incident command structure that is focused on completing the process as quickly as possible while ensuring compliance with

state and federal law. This effort will require an in-person site visit, fingerprint background study for individuals with a controlling interest in the provider organization, and verification of provider credentials for approximately 5,800 providers. From October 2024 through June 2025, DHS conducted visits to EIDBI providers to review a detailed checklist of required elements of an EIDBI provider. There were 324 visits conducted. Although these visits were announced, they were far more detailed than a pre-enrollment or revalidation site visit and we consider these sufficient for the EIDBI revalidation. DHS Licensing conducts licensing reviews for Adult Day Services and Intensive Residential Treatment Services. DHS is reviewing licensing visits conducted in 2025 and will consider a site visit complete if the review was unannounced.

To execute these actions in alignment with CMS direction, DHS will require tremendous additional, professional human capacity beyond what it currently has available for provider revalidation work. DHS has requested and already received reassigned staff from across Minnesota state government to implement Governor Walz' Executive Order, EO 25-10, and we similarly plan to request additional resources from across state government to satisfy CMS's requirements. The department intends to take the following additional actions:

- **January 23, 2026 - January 28, 2026**
    - Notice of revalidation requirements were sent to all 5,640 providers in the high-risk services.
        - DHS revalidated 1,127 of these 5,640 providers in 2025; of these 452 were screened at the high-risk level and are considered complete. The remaining 675 were screened at a lower risk level and will need to have an unannounced site visit and confirmation the background study requirements have been met. DHS will prioritize this group and get the site visits scheduled ahead of any new ones that need to be done.
        - DHS has also initiated revalidation in the last 6 months for 1,813 of the providers in these 13 service categories, all of the providers who respond will be screened at the high risk level which includes the fingerprint background study and unannounced site visit, those that do not will be terminated accordingly.
        - DHS is sending a list of all the owners of the provider organizations in this high-risk group, as well as all currently enrolled 300,000+ individual PCAs to CMS' Provider Enrollment Team for a Data Compare to ensure there haven't been any federal convictions that we were unable to locate/identify.
- **January 30, 2026**

- DHS to send CMS the following:
  - State laws and provisions associated with provider revalidation efforts
    - Minnesota Statutes, § 256B.04, subdivision 21.
    - DHS is working on a proposal that would consolidate the timeline for provider revalidations for the upcoming session.
  - Memorandum summarizing state law challenges and a proposal to overcome these barriers and expedite (see attached).

- **February 1, 2026**
  - Provide CMS with a staff training plan that includes staff resource constraints and figures on the following:
    - Number of state staff currently trained to do provider revalidation, broken out by whether staff supports site visit or application processing efforts: 20 staff are trained to conduct all aspects of the provider enrollment process.
    - Number of state staff who usually train new staff on provider revalidations: 5
    - Number of cross-state and/or contractor staff who will be working on provider revalidations and when they have been/will be trained on the provider revalidation process: DHS will engage approximately 170 additional staff, through both inter-agency agreements and contracting, to assist with site visits.
    - See the attached reports for the list of all high-risk providers, categorized by provider type, that the state needs to revalidate, along with the following:
      - when the provider was initially enrolled,
      - date of each provider's last revalidation
      - date of the most recent site visit
      - whether fingerprinting was captured during enrollment or previous revalidation
- **April 1, 2026**
  - Provider revalidation application deadline – All revalidation submissions must be submitted by this date to ensure timely processing and appropriate action is taken on providers who do not comply.
- **May 31, 2026**

- MN to complete their revalidation process and to deactivate those providers found to be non-compliant

Enhanced Prepayment Review Project

Through newly implemented and enhanced prepayment review process, DHS will use Optum to identify and report potentially concerning claims within each provider payment cycle. DHS will release unflagged claims for payment if Optum characterizes them as not concerning or "clean." Flagged claims are routed to the policy and program teams responsible for administration of the benefit associated with the suspended claims and follow up as needed with providers. DHS OIG may initiate site visits, if appropriate, and gather clinical documentation and other records to substantiate service delivery. Department staff may interview provider organization leadership, clinicians, and staff and/or interview program members who should have received services associated with the claims submitted to DHS for payment. If this process does not resolve concerns about the claims or a provider's billing behavior, the provider and all relevant associated information will be referred to the Department's Office of Inspector General (OIG) for formal investigation.

- **December 23, 2025**
  - DHS paused payments for 14 high-risk services to allow Optum to perform enhanced prepayment review.
- **January 13, 2026**
  - DHS released payment for "clean" claims paused in the first warrant cycle through December 23.
    - Approx. 1700 claims were flagged. After DHS review and consultation with policy areas, 14 claims were denied because an edit on the service agreement was forced by the case manager. All other claims were released and were paid on either 01/13/26 or 01/27/26 depending on submission date.
- **January 14, 2026**
  - For the warrant Cycle ending 1/9/26; Optum flagged 12286 claim lines (4,842 claims) for review and categorized below:
    - High= 78 lines (26 claims)
    - Medium= 9129 (3378 claims)
    - Low= 623 (114 claims)
    - Watch= 2459 (1322 claims)

  - Optum will ramp up the number of analytics applied each warrant cycle until it reaches the total number of approximately 190 analytics that have been refined and optimized for DHS based off 3 years of paid claims history.
    - The warrant cycle ending 01/23/26 consisted of 56 analytics, 112 will be applied on the warrant cycle ending 02/06/26 and the full approximately 190 by the 2/20/26 warrant cycle.
- **January 30, 2026**
  - Optum will provide DHS with a vulnerability assessment of the 14 high-risk programs. DHS will incorporate this information in our program assessment work and utilization oversight activities.
- **February 1, 2026**
  - DHS to provide CMS with an interim report on its enhanced prepayment review.
- **March 1, 2026**
  - DHS will send CMS a report of the findings from Optum's review of historical claims data.

Disenrollment of Inactive Providers

Minnesota began disenrolling inactive health care providers late this fall at the suggestion of CMS staff with the Centers for Program Integrity. On October 15, DHS disenrolled about 800 providers that were enrolled in the 13 high-risk services. On January 5, 2026, the Department disenrolled roughly 4,300 out of network and out of state managed care providers and will be disenrolling another 800 inactive providers on January 30, 2026. The Department is working with providers who contact us with valid reasons to delay or defer disenrollment. The Department will take the following additional disenrollment actions:

- **January 30, 2026**
  - DHS completed a review of an additional 13,000 inactive providers with our MCO partners on January 15, 2026. We identified about 2,000 providers who will need to receive notice of termination. About 1,000 providers will be sent Notice of Proposed Action letters on January 30 advising their enrollment will be terminated effective **March 2, 2026**.
  - Due to resource constraints, DHS will split this group into two parts and send the final 1,000 letters on February 15. We will terminate an additional 11,000 providers via batch job in early February.
- **March 1, 2026**

- DHS will share a report with CMS detailing the process for deactivating inactive providers. This process identifies inactive providers every 6 months and commences the disenrollment process following an internal review.

Claims Editing System (CES) Assessment

- **January 30, 2026**
  - Optum delivered DHS a Claims Editing System (CES) assessment. As a claim is received from the clearinghouse/provider, it runs through the pre-adjudication process of checking for eligibility, coordination of benefits, and provider verification. Within the mid-adjudication, prepayment cycle, claims are routed for clinical editing, applying clinical and policy edits. The State provided six months of data to support the CES team assessment on November 24, 2025. This data was validated and accepted by Optum for use in an assessment on December 5, 2025. Based on the assessment, the following work will occur:
    - DHS will review the assessment Optum provides and determine if any MMIS claims edits aren't operating correctly. Edits that are not working as intended will be forwarded to MMS programmers to be fixed.
    - DHS will work with system programmers to implement and test for effectiveness and accuracy of system edits.
- **February 1, 2026**
  - DHS to provide CMS with a report on its CES Assessment.

External Management Consultants Procurement

- **February 1, 2026**
  - MN to provide CMS with a report outlining how they plan to optimize their external management consultant procurement process (see attached)

Use of Advanced Analytics and Predictive Indicators

The Minnesota Department of Human Services (DHS) is strengthening Medicaid program integrity through the expanded use of advanced analytics, automated indicators, and data-driven dashboards to support risk-based oversight across provider enrollment, claims payment, and post-payment review. DHS's analytic approach is designed as a closed-loop oversight framework in which risk indicators inform operational action, outcomes are measured and validated, and analytic thresholds and processes are continuously refined.

This structure ensures analytics functions as integrated program integrity controls rather than standalone tools.

Current capabilities are limited to rules-based and descriptive analytics and do not include automated decision-making or machine learning models. All current and planned analytic enhancements are subject to legislative authority and approval by the Centers for Medicare & Medicaid Services (CMS) through the Advanced Planning Document (APD) process.

Risk Identification Using Analytic Dashboards and Automated Indicators

- **Implemented in Q4 2025**
    - DHS developed and deployed analytic dashboards for 14 high-risk service types that apply standardized risk metrics and descriptive indicators to identify potentially concerning provider and billing behavior. These dashboards are advisory in nature and support risk identification, prioritization, and human review. These dashboards support:
        - Peer-group utilization comparisons by service type, geography, and provider characteristics.
        - Identification of billing outliers and sudden billing spikes.
        - Flagging of frequency and behavioral patterns that may warrant further review.

Use of Analytics to Prioritize Prepayment and Post-Payment Review

- **Implemented in Q4 2025**
    - Launched a business process redesign effort to align post-payment review activities with data-driven risk indicators generated through analytic dashboards.
    - Contracted with vendors to support development of a tip prioritization framework and vulnerability assessments.
    - Contracted with a vendor and began implementation of prepayment review analytics for the 14 high risk service types.
- **March 31, 2026**
    - DHS will expand the use of historical, multi-year claims data within analytic dashboards to support post-payment audits and referral processes for 14 high-risk service types, with assistance from contracted vendors.
- **September 30, 2026**

    - DHS will incorporate dashboard-based risk indicators into prepayment review workflows, including reviews conducted with assistance of contracted vendor.
    - DHS will flag atypical service combinations and billing patterns that warrant additional documentation or review.
- **March 31, 2027**
    - DHS will expand the use of historical, multi-year claims data within analytic dashboards to support post-payment audits and referral processes for all service types, with assistance from the Data Analytics and Systems Group in CMS' Center for Program Integrity and the state's contracted vendors.
    - Risk indicators will be applied proportionally across the provider and payment lifecycle, with lower-risk signals informing monitoring and higher-risk, validated patterns informing prepayment review, post-payment audit selection, or referral pathways.

Operational Use - Dashboard-generated indicators are used to:

- Identify providers that may warrant additional documentation or pre or post payment review
- Prioritize post-payment audits, site visits, and targeted reviews
- Inform referrals to DHS program areas or the Office of Inspector General (OIG), with documented human review prior to any adverse action

Analytics do not independently trigger payment denial, suspension, or recoupment and are used solely to support risk-based prioritization and oversight decisions.

Benchmarks - Demonstrated correlation over time between dashboard-flagged indicators and confirmed audit or review findings:

- Documented analytic rationale included in audit selection, prepayment review, and referral decisions.
- Increased consistency and transparency in how reviews are prioritized across DHS program areas.
- Reduction in time required to identify and prioritize high-risk providers compared to pre-dashboard processes.

Validation, Monitoring, and Governance

- **September 30, 2026**
    - DHS will establish a documented analytic governance process to track outcomes associated with dashboard-flagged indicators, including audit

findings, investigations, referrals, and recoveries. Indicator thresholds and rules will be periodically reviewed and refined based on validated outcomes and operational experience. Governance artifacts will include documented indicator methodologies, change logs, outcome analyses, and periodic review summaries retained for audit and CMS review. Benchmarks include:

- Documented review of dashboard indicators conducted at least semi-annually.
- Monitoring of false positives and indicator performance to improve precision over time.
- Continued human review and due-process safeguards prior to any payment suspension, denial, or recoupment.

Planned Enhancements (Subject to Legislative Authority and CMS APD Approval)

Consistent with a phased modernization approach, DHS and the Governor's Office will work with the legislature in 2026 to strengthen statutory authority and secure funding to support expanded, risk-based program integrity capabilities across the provider enrollment and payment lifecycle. These changes would authorize DHS to modernize analytics infrastructure, prepayment and post-payment oversight processes, and feedback integration, establishing a foundation for more advanced analytic methods over time.

The Governor's proposals will enable DHS to design, train, and deploy advanced statistical and machine learning–based models to augment existing dashboard-based indicators. These models would be used to identify complex, non-obvious risk patterns across large volumes of enrollment, claims, and encounter data that are not readily detectable through rules-based methods alone. Model development would be phased, beginning with supervised approaches informed by validated audit findings and investigative outcomes, and expanding incrementally as accuracy, performance, and governance controls are demonstrated. Any advanced analytic or machine learning models would be introduced through limited pilot use cases with defined performance thresholds and CMS-approved APDs prior to operational use.

Additional proposed statutory changes would strengthen provider licensing and enrollment by establishing structured, data-driven risk and readiness assessments prior to enrollment, enhancing verification of business legitimacy, deterring false or misleading applications, and clarifying the Commissioner's authority to apply enhanced screening in higher-risk program areas. Risk indicators generated through post-payment reviews would

be incorporated into front-end screening processes to create a continuous feedback loop across the provider and payment lifecycle. The Governor's Office and the Department will also work with the legislature on enhanced billing and payment oversight and documentation requirements, additional service and billing limits, expanded use of prior authorization, additional fines for licensing violations, and additional statutory authority to employ payment withholds.

The Minnesota Department of Human Services requests CMS' collaboration in this federal and state enterprise as we undertake these important reforms to assure effective oversight of our programs and early prevention and detection of fraud. The Governor's Office and the Department are open to working with the legislature on any additional program integrity enhancements suggested by CMS, the HHS OIG, and federal law enforcement partners.

The actions detailed above demonstrate Minnesota's continued commitment to enhance and strengthen program integrity and swiftly identify and address fraud, waste, and abuse in its Medicaid program. We welcome partnership, guidance, and direction from CMS to ensure that Minnesota Medicaid is a leader in program integrity and continues to serve and benefit our most vulnerable citizens.

Sincerely,

John M. Connolly, Ph.D., M.S. Ed.
Deputy Commissioner and Minnesota Medicaid Director