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December 31, 2025

Kim Brandt, Chief Operating Officer and Deputy Administrator
Daniel Brillman, Deputy Administrator
Centers for Medicare & Medicaid Services (CMS)
7500 Security Blvd.,
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Subject: **Corrective Action Plan for Program Integrity**

Deputy Administrators Brandt and Brillman:

This Corrective Action Plan (CAP) is in response to your letter of December 5, 2025, in which you requested a plan from Minnesota to strengthen program integrity and anti-fraud actions within its Medicaid program. As we stated in our December 17 reply to your letter, we strongly agree that assertive, ongoing action is necessary. Governor Walz issued Executive Order (EO) 25-10 on September 17, 2025, to bolster and expand this work. The Department of Human Services (DHS) has been proactive beyond the items in the EO, including taking 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 disenrolling over 800 inactive providers in October 2025 alone.

DHS values the opportunity to partner with CMS through this Corrective Action Plan (CAP) to add to the program integrity actions Minnesota has already taken. As detailed below, DHS fully supports CMS's direction to prevent, detect, and investigate fraud in our Medicaid program even more aggressively.

Minnesota's CAP includes the following actions:

- **Implement a provider enrollment moratorium for all 14 high-risk services that DHS identified and that are referenced in CMS's December 5th letter.** DHS has determined that these 14 services are high-risk based on a number of factors, including: tips, referrals, investigative findings, data analysis, and an assessment of program vulnerabilities. The high-risk designation provides DHS with the ability to install additional program integrity oversight to prevent fraud on the front-end before program weaknesses could be exploited. DHS is continuing to investigate programmatic vulnerabilities and remains on the lookout for emerging concerns. DHS is also implementing a temporary licensing moratorium for Home and Community Based Services providers and an enrollment moratorium on new autism service providers. DHS is also implementing a temporary licensing moratorium for Adult Day Services. As mentioned above, Minnesota also worked with CMS to terminate the Housing Stabilization Services benefit, effective October 31, 2025. These actions effectively pause provider enrollment for 8 of the 14 high-risk services. Minnesota agrees with CMS' recommendation for a broader moratorium and will implement a six month pause on provider enrollment for all high-risk services effective January 8, 2026. In recognition of the statutory obligation to ensure enrollee access to critical Medicaid-covered services, 42 C.F.R. § 455.470(a)(3)(ii), Minnesota will provide CMS with written notification of any proposed exceptions to the enrollment moratorium detailing the basis of its concerns.

- **Implement an immediate, off-cycle revalidation of all providers of the 14 high-risk benefits.** In its December 5th letter, CMS strongly recommended DHS complete this action as soon as practicable. We agree with CMS's direction and have established a plan 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. To execute these actions in alignment with your 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 in an attempt to meet CMS's requirements.

At the same time, Minnesota law is proscriptive regarding how DHS can implement provider revalidations, including significant timing and notice restrictions. *See* Minnesota Statutes, § 256B.04, subdivision 21. DHS welcomes guidance from and dialog with CMS on how to best meet CMS's direction and timing requirements in a legally compliant manner.

Compliance with high-risk provider revalidation also includes DHS verification that a fingerprint background study has been completed and cleared by those individuals with five percent or more ownership in the provider entity. Currently, DHS has the legal authority and capability of conducting fingerprint studies for 10 of the 14 service types within this high-risk group. *See generally* Minnesota Statutes, Chapter 245C. Currently, DHS does not see how it can comply with CMS direction and Minnesota law; however, DHS is actively developing a solution to conduct required studies for the remaining 4 service types and will undergo revalidation of those providers upon securing this capability. DHS again welcomes guidance and direction from CMS on how to meet CMS's requirements while complying with applicable law. DHS will also continue to independently work on potential solutions and will report a target date to CMS as soon as possible.

DHS intends to begin revalidation on 9 of the 13 service types (as Housing Stabilization Services has been terminated) on January 5, 2026. Due to the large number of providers requiring revalidation, Minnesota respectfully requests significant resources from CMS to accomplish the aggressive revalidation timelines demanded by CMS. We also request the assistance of CMS' Unified Program Integrity Contractor to complete document review and high-priority site visits. As mentioned, DHS also intends to request additional state employee redeployments needed to revalidate approximately 5,000 providers. With these additional resources and in light of the statutory timelines required under state and federal law, DHS anticipates completion of revalidation of these providers by May 31, 2026. The revalidation timeline under this accelerated schedule for the remaining approximately 1,000 providers in the 4 additional service types will be developed in consultation with the provider enrollment team from the Centers for Program Integrity as we seek authority to complete that workload.

- **Disenroll inactive providers who have not billed for Medicaid services within the previous year.** In October 2025, to reduce the administrative burden of provider oversight and revalidation, DHS disenrolled over 800 providers that had not billed in the prior year. The Department will now immediately disenroll an additional approximately 4,300 out-of-network and out-of-state providers within managed care organizations' networks for the same reason.

DHS will send notifications to approximately 800 additional providers to notify them of their inactive status and our intent to terminate their enrollment as a Medicaid billing provider. The Department will disenroll providers who are not adequately responsive by January 30, 2026. A review of an additional 13,000 providers should be completed by end of February 2026. All providers are being reviewed for network adequacy and access needs.

- **Implement enhanced prepayment review of the 14 high-risk services through a contract with Optum.** Through a newly implemented and enhanced prepayment review process, DHS will use Optum to identify and report potentially concerning claims within each provider payment cycle. The Department's Medicaid Payment and Provider Services (MPPS) Division will release unflagged claims for payment if Optum characterizes them as not concerning or "clean," while the MPPS team will send claims to the appropriate policy and program teams for further review if they are identified as potentially concerning.

  The policy and program teams responsible for administration of the benefit associated with the suspended claims will review the claims and follow up as needed with providers, including site visits if appropriate. This action will gather necessary clinical documentation and other records to substantiate service and support billing. 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.

  This is a very new enhanced prepayment review process. Payment for claims in the 14 high-risk services were paused on December 25, 2025 to allow Optum to perform enhanced prepayment review. DHS anticipates receiving the first report of prepayment findings from Optum soon. DHS anticipates the report will contain information about specific providers and billing entities and potentially concerning billing patterns. DHS will release payment to providers once we are able to identify claims as "clean" or after the relevant policy teams can resolve concerns about claims that Optum flagged as possibly problematic.

  Generally, we will release "clean" claims for payment within the customary 30-day timeframe, and we will release complex claims within a 90-day timeframe if further review is needed from policy teams to resolve concerns. Claims with possible evidence of fraudulent or other concerning activity will be referred to the OIG with a continuing payment suspension and possibly resulting in a provider payment withhold action depending on the evolution of an investigation.

DHS also expects to receive a report from Optum by the end of January that is focused on a historical review of claims paid in the 14 high-risk services over the last three years. DHS will provide this report when it is complete, available, and reliable.

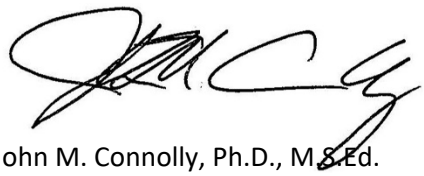
In 2026, DHS will also release a request for proposals (RFP) to secure a longer-term vendor to conduct an even more expansive and continuing prepayment review for all Medicaid services, based on capacity, after the initial one-year Optum contract term expires.

- **Conduct a claims editing system (CES) assessment to pinpoint vulnerabilities in claims and identify opportunities for improvement.** Optum will deliver a CES Assessment by January 22, 2026. 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, pre-payment 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. Optum has initiated the analysis and is on schedule to deliver the assessment by January 22, 2026.

- **Release an RFP to secure an external management consultant vendor to provide long term recommendations for restructuring the Department's organization and processes as the single state Medicaid agency to optimally support program integrity as an integral, core function and identity**. The Department plans to release the RFP in January 2026 and begin implementation of the vendor's recommendations as soon as practicable.

The actions detailed above demonstrate Minnesota's commitment to aggressively strengthening program integrity in its Medicaid program. We welcome further guidance and direction from CMS to ensure we are combatting fraud while also taking care of Minnesota's most vulnerable citizens. We look forward to ongoing engagement with CMS, including in scheduled weekly meetings, about this plan and your collaboration in this work.

Sincerely,



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