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.

Minn. Stat. 13.37 (Security/Trade Secret Information) [redacted], 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:

- [redacted] Minn. Stat. 13.37 (Security/Trade Secret Information)
- [redacted]
- [redacted]
- [redacted]

- Minn. Stat. 13.37 (Security/Trade Secret Information)

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:

- Minn. Stat. 13.591/13.599 (contract negotiations) [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- **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:
    - Minn. Stat. 13.37 (Security/Trade Secret Information) [redacted]
    - [redacted]
    - [redacted]

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.

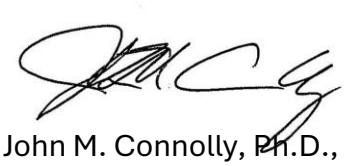
Additional proposed statutory changes would strengthen provider licensing and enrollment by establishing structured, data-driven risk and readiness assessments prior to enrollment, enhancing verification of business legitimacy, deterring false or misleading applications, and clarifying the Commissioner's 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